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A PILOT STUDY TO IDENTIFY INFRASTRUCTURE BUILDING ACROSS HRSA PROGRAMS

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EXECUTIVE SUMMARY

STUDY GOALS

The Health Resources and Services Administration (HRSA), through a variety of programs, promotes access to quality health care for underserved, vulnerable, and special needs populations. This is accomplished in part by creating an infrastructure that supports the health care safety net that assures the availability of personal health care services. HRSA's Office of Planning, Evaluation, and Legislation (OPEL) contracted with Mathematica Policy Research, Inc. (MPR) to conduct a pilot study of how HRSA money is used at the local level to create and maintain this safety net. The study has two goals. One is to describe how HRSA programs contribute to the development of a health infrastructure at the community level. The other is to test the use of a site visit methodology to gather this information.

Communities often receive funds from numerous HRSA programs, such as Ryan White, the Maternal and Child Health Title V block grant, Community and Migrant Health Centers, and the National Health Service Corps. The question therefore arose of whether it is possible to examine a community and describe how HRSA programs contribute to its health care infrastructure and how the many streams of HRSA funds collectively affect the development of the infrastructure. The results of the study are intended to help the agency develop measures of the activities designed to develop and sustain the health care infrastructure. Until now, HRSA has found it difficult to convincingly describe and highlight the value of such activities.

METHODS

The study team made two-day site visits to three communities--Boston, Massachusetts; Cleveland, Ohio; and Phoenix. Arizona. The three sites were selected from the communities that are being studied by the Center for Studying Health System Change as well as the Public Health Tracking Study conducted by MPR. Limiting the choice of study to those communities ensures that a wealth of contextual information is available on the communities and that the communities represent a diversity of market characteristics. This is important because HRSA wanted to observe the influence of market changes on its programs. Additional criteria for site selection were the presence of a range of HRSA programs and geographic diversity.

Each community was visited simultaneously by two research teams. Each team consisted of one MPR senior health researcher, at least one representative from OPEL, and at least one representative from a HRSA programmatic area. This arrangement let HRSA program representatives view closely both programs they were familiar with as well as some HRSA programs with which they were less familiar.

Site visitors used semi-structured interview protocols to conduct one- to two-hour interviews with program directors, staff, subcontractors, practitioners, and others. The information obtained in interviews was supplemented with background information on each program. The principal

programs targeted in the interviews were Ryan White Titles I and II, Special Projects of National Significance, AIDS Education and Training Centers, the Title V Maternal and Child Health Block Grant, Community Integrated Service Systems, Healthy Start, Community Health Centers, Primary Care Associations, Primary Care Organizations, Area Health Education Centers, the National Health Service Corps and Title VII primary care training grants.

FINDINGS

The findings from this pilot study are organized around the themes that characterize the infrastructure-building activities of the study communities: (1) developing and sustaining effective collaborative relationships within and across HRSA programs, (2) assessing the need for services, (3) developing financial resources, and (4) developing and distributing human resources.

Developing and Sustaining Collaborative Relationships

This study hypothesized that community infrastructure benefits from the investment of numerous HRSA programs in one place, and collaboration among programs. Study questions therefore investigated both the extent and impact of collaboration. HRSA enhances this collaboration by requiring grantees to develop and sustain formal structures for encouraging community participation, such as consortia and community-based boards. Building collaborative relationships, however, is not easy, as shown by the experiences of Ryan White planning councils and Healthy Start consortia. For some councils/consortia, collaborative relationships are hampered by turf issues, muddled lines of responsibility, the absence of a clear mission, and problems in engaging the participation of key stakeholders. However, some of the sites we visited have moved beyond these difficulties and are now reaping the benefits of collaboration. HRSA management practices are in some cases instrumental in establishing collaboration and infrastructure development.

The communication among disparity groups that occurs in well-functioning consortia encourages functioning groups that promoted better ways to combine, target, and allocate resources. For example, these bodies allow providers and a variety of community representatives to work together to address a single issue affecting vulnerable populations. In some cases, disparate efforts have been channeled to reduce duplication. In increasingly competitive markets, collaboration is key to ensuring that the needs of vulnerable populations are addressed and that their traditional health care providers survive.

Because of the difficulties involved in establishing collaborative relationships, the people we talked to suggested that HRSA play a stronger role by (1) more clearly defining the purposes and expectations for collaboration for its programs, (2) ensuring collaboration among programs at the federal level before the related local programs are asked to engage in this difficult process, and (3) establishing more compelling incentives for programs to collaborate.

Assessing and Planning Activities

Strong health care systems for poor or otherwise vulnerable populations become stronger when the limited available funds are distributed equitably and efficiently across programs. In the changing health care market, coordinated assessment and planning activities may make the difference in being able to play an effective role in state and local health policy decisions.

HRSA policies promote planning activities that foster this kind of rational allocation of limited resources. For instance, the grant application process and other program activities generally require some form of formal needs assessment and planning activities. While this process is somewhat perfunctory for some programs in some communities, for others it served as an important tool for setting program priorities. Assessment and planning activities have also had a significant impact on the ability of program staff to identify opportunities for improving services and for solving delivery system problems.

We observed numerous examples of better-coordinated and better-integrated services that have come about as the result of local efforts to assess the service delivery landscape, to streamline services, and to share fiscal and human resources. We also observed service delivery systems in which coordination and integration were less than ideal because opportunities for improvement were missed. For example, community health centers, primary care office programs, and maternal and child health programs often did not coordinate their assessment and planning activities even though these programs serve some of the same populations.

Local program managers had several suggestions for HRSA management about how to facilitate assessment and planning activities. HRSA should review data requirements for major HRSA programs and develop a common template for a core set of needs assessment data, and required data should be available from existing data sets to the greatest possible extent. HRSA should also take a strong role in encouraging data sharing and planning activities among programs serving similar populations.

Developing Financial Resources

HRSA funds are not typically the total support of an organization--indeed, they are usually only a small portion of revenues. However, the value of even a small amount of funds can be enhanced if the money is used creatively and efficiently. We were told repeatedly that HRSA funds, regardless of the amount, are used to leverage additional funds to support individuals or institutions and to expand programs. According to our informants, some essential services would not exist or would be significantly reduced without this HRSA funding.

Changes in the health care market, particularly the restructuring of private sector provider organizations to expand service areas and improve market share, have become a threat to some HRSA grantees. CHCs in particular are challenged to remain financially viable in increasingly aggressive markets. We heard of CHCs developing strategic alliances among themselves and with other providers to more effectively compete and ensure services for vulnerable populations. We also heard that trying to compete and leverage funds can distract from a program's safety net mission.

But generally, HRSA funding and grant requirements help programs staff to stay focused on serving vulnerable populations. For example, despite strong market pressure, CHCs often have relied on grant requirements to resist integrating with noncommunity-based health plans and hospitals that do not share their community-based philosophy.

Developing Human Resources

A key barrier to health care access in underserved communities is the lack of physicians who can address patients' health care needs in a way that is congruent with their social and economic environment. HRSA training programs are far-reaching. Agency-supported family medicine and other training programs expose residents and students to safety-net providers, letting them see how care can be tailored to the special needs of vulnerable populations. Moreover, training programs provide an opportunity for health providers to identify students as potential new employees who can bring new knowledge and up-to-date practice guidelines to a community.

Market forces draw practitioners away from the inner city, creating underserved areas. CHCs are often at a competitive disadvantage in terms of hiring and retaining providers because they are lured away by the better working conditions, higher salaries, lower administrative burden in the private sector. Numerous respondents reported the importance of National Health Service Corps. providers in helping to overcome the human resource deficit in safety net providers.

METHODOLOGICAL LESSONS

As a learning tool for HRSA management, the pilot study has been useful in several ways. First, it has given HRSA representatives both first-hand knowledge of concrete infrastructure-building activities and the opportunity to observe in person a variety of HRSA programs. Second, the study provided an opportunity for informants and HRSA representatives to express numerous ideas for improving HRSA programs. In many cases, these ideas have to do with the areas in which programs need technical assistance from HRSA. Other ideas take the form of specific suggestions for improving how HRSA programs conduct activities. The study also suggested possible indicators that HRSA might use to define measures of program performance in infrastructure building. Finally, the exploratory nature of this pilot study encouraged brainstorming, which generated new ideas and hypotheses that could be tested in more formal evaluations of HRSA programs.

Overall, the pilot study shows that a reasonably low-cost approach to site visits along with a rapid assessment of results can help HRSA understand the collective impact of its programs in a community. The project also reveals the components that underlie infrastructure-building activities. While these components need to be further refined. they can provide a framework for future studies of this sort which may help HRSA managers improve access to care in underserved communities and for underserved populations through infrastructure development.

I. INTRODUCTION

In fall 1997, the Health Resources and Services Administration (HRSA), one of the eight Public Health Service (PHS) operating divisions of the Department of Health and Human Services (DHHS), contracted with Mathematica Policy Research, Inc. (MPR) to conduct a pilot study that would take the first step in determining whether it is possible to measure HRSA efforts to develop the public health infrastructure using a rapid assessment site visit methodology. HRSA is responsible for leadership in "general health service and resource issues relating to access, equity, quality and cost of care" (HRSA 1993). To this end, HRSA distributes it resources to communities to provide services to many vulnerable groups including low-income people living with AIDS, children with special health care needs, and individuals residing in underserved geographic areas. Communities provide these services through a variety of programs that promote access to quality health care, improve service delivery, provide health education, train health professionals, and serve underserved and vulnerable populations. Many communities receive several HRSA grants to provide direct services. These grants also often create the infrastructure, or framework, needed to ensure the availability of personal health care and population-based public health services.

The study documented in this report was commissioned as part of HRSA's effort to assess two aspects of its mission: (1) how its programs help communities address their health care needs and (2) its role in helping communities respond to the current rapid and dramatic market changes that also affect the public sector health care system. Specifically, HRSA asked MPR to identify (1) the ways in which HRSA programs facilitate infrastructure building at the community level, (2) the influence of market changes on HRSA programs, and (3) lessons from the methodology piloted in the study.

Previous work commissioned by public and private sponsors in 12 communities provided the background for the study.[1] The public health care system in these communities is rapidly and dramatically changing. States are taking a variety of approaches to Medicaid managed care, and, in response, the structure of public health services in many of the communities is changing. To test the ability to observe the influence of market changes on HRSA programs and program responses to these changes we visited sites with different managed care penetration rates and proportions of uninsured residents.

The ability to measure the effect of HRSA infrastructure-building activities rests on an understanding of the infrastructure itself and its development in the context of HRSA programs. This study represents the first step toward this understanding. Structured interviews provided a systematic way to examine how grant managers and providers see the role of HRSA programs and how they contribute to infrastructure building. The interviews explored the interrelationships among HRSA programs, with a special focus on how they can be mutually reinforcing and how they stimulate and improve services to vulnerable populations.

'The Community Tracking Study is a major initiative of the Robert Wood Johnson Foundation to track changes in the health care system over time and to gain a better understanding of how health systems changes are affecting people. The Public Health Tracking Study is sponsored by the Department of Health and Human Services, Office of Disease Prevention and Health Promotion. It is a collateral study to the Community Tracking Study that tracks changes in the health care system and how they impact local health departments' ability to carry out population-based services. For more information on these studies see Kohn L., Kemper, P., Baxter, R., Feldman, R. Ginsberg, P. (editors). Health System Change in Twelve Communities. 1997 Center for Studying Health System Change; Washington, DC; and Martinez, R. M, Closter, E., and St. Peter, R. County-Level Tracking of Public Health Functions and Policy Issues. Year 1: Interim Report. December 1997, Mathematica Policy Research, Washington, DC.

A. PROGRAM BACKGROUND

Reforms in state and local markets are rapidly transforming the delivery and financing of health care, and these changes are having a tremendous impact on the public health care system. The combined effects of dwindling resources, fragmented services, managed care, and an increasing number of uninsured people are prompting policymakers to help community organizations to come up with new ways to deliver public health services and to be accountable for their choices. At the same time, the Medicaid and the Child Health Insurance Programs have expanded coverage for some individuals who have relied on local health departments and HRSA-funded service delivery. Grantees that implement HRSA programs have an opportunity, and are required in some cases, to view their programs in a community context, as being an integral part of the community resources that address public health needs. This pilot study was seen as a way to help HRSA management develop a strategy for assessing the extent to which its programs are achieving their infrastructure-building objectives.

The study explores the ways in which HRSA programs interact at the community level to build infrastructure. These programs cluster around four service areas: (1) HIV/AIDS, (2) maternal and child health , (3) primary care services, and (4) health professions training. A brief description of the programs in each cluster follows. Not all HRSA grant programs could be included in the study since not all programs are represented in the cities visited.

1. HIV/AIDS Cluster

a. Ryan White Title I

Title I of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CARE Act) is a grant program for cities that have reported 2,000 or more AIDS cases to U.S. Centers for Disease

Control and Promotion. The grant funds community-based outpatient health and support services for low-income persons living with HIV/AIDS and for their families. Services include prescription drugs, case management, counseling, transportation, nutritional services, home and hospice care, and many other support services. Each Title I grantee is required to establish a planning council responsible for setting priorities for funds. The council must consist of representatives from 11 specific groups, such as state and local health agencies, consumer groups, and other community organizations.

b. Ryan White Title II

Funding from Title II of the Ryan White CARE Act flows to states to develop comprehensive plans for providing health care and support services to people living with HIV/AIDS and to their families. Funding is distributed among states according to a formula based on (1) the number of AIDS cases reported in the state during the most recent two-year period and (2) the per capita income of the state relative to the national average. States may use their Title II funding to support one or more programs in the following categories: developing HIV care consortia, providing home and community-based care services, assisting with health insurance coverage, and providing treatments and pharmaceuticals. States that receive Title II funds must match the federal Ryan White Title II grant according to a yearly formula.

c. Special Projects of National Significance (SPNS)

The SPNS is a grant program funded through Part F of the Ryan White CARE Act and administered by the Office of Science & Epidemiology of the HIV/AIDS Bureau. This program was established in 1991 to advance knowledge about treatment and care for people with HIV/AIDS. Using a competitive grant-award process, the SPNS program provides financial assistance to

nonprofit organizations that want to conduct evaluations and/or demonstrations of innovative and replicable models for delivering health and support services to people with HIV/AIDS. Past SPNS program models have focused on such issues as managed care; improving access to care; special issues relating to the care of women, adolescents, children, and rural residents; services for people in prisons; and the integration of mental health and primary care services.

d. AIDS Education and Training Centers (AETC)

The AETC is a network of regional centers that conduct targeted, multidisciplinary education and training programs for health care providers. The objective of the program is to increase the number of health care providers who are educated to counsel, diagnose, treat, and manage care for persons with HIV/AIDS and to help prevent high-risk behavior that may lead to infection. AETCs collaborate with other Ryan White CARE Act-funded organizations, Area Health Education Centers, and community-based medical and professional organizations.

2. Maternal and Child Health (MCH) Cluster

a. Title V Maternal and Child Health Block Grant

Title V of the Social Security Act functions as a state/federal partnership. States have authority to allocate funds to meet their own needs; however, they are also required to use at least 30 percent of Title V funds to provide preventive and primary care services for children, and at least 30 percent to provide services for children with special health care needs. The grant also supports services for mothers. Title V programs either financially support or directly manage such services as prenatal care, child health services, school health services, and educational programs. For example, Title V makes prenatal care accessible to approximately 3.6 million women and primary health care accessible to 8 million children. In addition to being required to coordinate with other federally

funded health, education, and social service programs, Title V-funded programs are responsible for several core functions. These functions include, but are not limited to, needs assessments, program planning and development, service delivery, technical assistance, and education.

b. The Community Integrated Service System (CISS)

CISS is a federal set-aside program under Title V that provides support for the development and expansion of integrated community service systems. These systems are public/private partnerships between health-related and other relevant community organizations and individuals that attempt to solve community-defined health problems with community resources. In particular, the CISS program seeks to reduce infant mortality and improve health outcomes of women and children, especially those with special health needs and/or who are living in rural areas. The CISS program has identified 10 key characteristics that make a community-based system of care effective: collaboration, family orientation, cultural competency, coordinated services and resources, comprehensiveness, universal applicability, accessibility, developmental orientation, and accountability.

c. **Healthy Start**

Healthy Start was originally designed to reduce infant mortality by 50 percent over five years in 15 areas. Since that time, the program has been extended beyond the five years in the original 15 sites and expanded to numerous other sites around the country. To be eligible for a grant, a candidate project area must have an infant mortality rate of at least 150 percent of the U.S. average for the five-year period 1984-1988; the area must also have at least 50 but no more than 200 infant deaths per year. In the first year of the project, demonstration sites developed community consortia, conducted needs assessments, and designed action plans for implementing health care and social

support services. An outcomes and process-oriented evaluation is currently being conducted in the 15 demonstration sites to assess program effectiveness. The demonstration phase of Healthy Start ended in September 1997. This marked the beginning of Phase II, in which the original 15 Healthy Start projects (including grantees in two of the cities visited for this project) were funded to act as mentors to 40 new Healthy Start projects.

3. Primary Care Cluster

a. Community Health Centers

Funded under Section 330 of the Public Health Service Act, the Community Health Center (CHC) Program is a federal grant program designed to provide primary health care and related support services in medically underserved areas throughout the nation. The program funds approximately 685 centers. CHCs address access and other health care problems by tailoring services to the community. Each 330-funded CHC is required to have a governing board composed, in part, of CHC users.

b. Primary Care Offices

Primary Care Offices (PCOs) promote access to community-based primary care services for underserved and vulnerable populations in each state. PCOs are strategically placed in the state health department, giving them access to a variety of state government agencies . These include the program offices of maternal and child health, rural health, mental health and substance abuse, primary care services, Medicaid, and primary care clinician training and placement programs. Clinical leaders in each of these resource areas may work with the PCO to develop and implement strategies for providing improved access to services. In addition, the PCO is responsible for fostering relationships with health profession schools for the purpose of recruiting and retaining

providers to care for the underserved. In some states, PCOs are responsible for designating Health Professions Shortage Areas.

c. Primary Care Associations

Primary Care Associations (PCAs) are private, nonprofit associations representing primary care centers and practices in the state that are supported by the Bureau of Primary Health Care (BPHC). Governed by a board of directors, each PCA must have equitable representation, including at least one practicing primary care clinician from each BPHC-supported center. The advantage of this governance structure is that each member center or practice has a direct link with the PCA, giving them a voice in issues affecting community-based services and geneially enhancing communications. PCAs are usually located in or near the state capitol to facilitate collaborative relationships between the PCA, the PCO, and other related state offices. PCAs and PCOs must submit a formal Memorandum of Agreement (MOA) with the BPHC detailing their goals and responsibilities for the following year, including how they will collaborate with each other, both directly and through their influence on primary care-related state programs.

4. Health Professions Training Cluster

a. Area Health Education Centers

The Area Health Education Center (AHEC) program is dedicated to addressing the shortage of primary care services, common to certain communities, by creating collaboration and partnerships between academic health centers and these communities. AHECs seek to meet the needs of underserved communities in several ways, including promoting the training and retention of primary care physicians in the community. To achieve this goal, AHECs create linkages with community-based groups and sponsor outreach programs such as medical interpreter training programs,

elementary and high school health career and mentoring programs, and continuing education for health care professionals. There are now 37 AHEC programs distributed throughout 36 states.

b. National Health Service Corps

The mission of the National Health Service Corps (NHSC) is to improve primary health care services in underserved communities nationwide. The NHSC offers student internships, mentoring programs, and financial incentives, such as scholarships and loans, that require or encourage health professionals to practice in underserved communities. The NHSC, which places clinicians in communities designated as HPSAs, is an important source of primary care providers for many federally sponsored CHCs.

c. Grants to Departments of Family Medicine

HRSA grants are awarded to establish, maintain, or improve academic administrative units to provide clinical instruction in family medicine. Grants may also be used to plan and develop model educational predoctoral, faculty development, and graduate medical education programs in family medicine that support academic and clinical activities relevant to the field of family medicine. To support the objective of increasing access to primary care services, the program gives preference to departments that have a high rate for placing graduates in practice settings having the principal focus of serving residents of underserved communities.

B. -METHODOLOGY

1. Analytic Framework

While each HRSA program has its own objectives, the programs share the goal of creating, harnessing,. and coordinating resources to promote the access to primary care services for

underserved and vulnerable populations. We hypothesize that, HRSA programs work synergistically to meet this goal at the community level, and contribute to the health care infrastructure in the communities served by HRSA programs. We also hypothesize that the degree to which HRSA programs contribute to infrastructure will be observable through the extent to which programs (1) develop and sustain effective collaborative relationships internally and with other HRSA programs, (2) assess community needs, identify problems, and work together to solve them, (3) leverage HRSA funds to secure additional funding to sustain or expand program activities, (4) promote or participate in the training of health care workers who can meet the health care needs of vulnerable populations, and (5) successfully cope with changing market forces.

2. Site Visit Approach

During February and March 1998, the research team conducted site visits to three communities--Cleveland, Ohio; Phoenix, Arizona; and Boston, Massachusetts. These communities served as the testing ground for a pilot methodology to systematically obtain grantees' views on the role of HRSA programs in building infrastructure and for refining research questions about the best ways to recognize and describe the benefits of infrastructure-building activities. Communities were selected from among 12 Community Tracking Study sites to provide a variety of public health care systems and markets for study. Site selection criteria included population size and composition, percentage of the population that was uninsured, degree of managed care penetration, the role of public health in the health care system, and whether the community received HRSA funding through any or some combination of the HRSA programs described in the previous section. Sites were prioritized as candidates, and HRSA representatives chose three sites in order to achieve the following mix: at least one site receiving Ryan White Title I funds; at least one site having a significant Hispanic

population; at least one site having a Healthy Start program; all sites receiving CHC funding; and, taken together, sites representing geographic diversity. Given that the sites were selected judgmentally, and that observations from a pilot study are exploratory, study results cannot be generalized to other communities or to other HRSA program grantees.

Two research teams visited each site. Each team consisted of one MPR senior health researcher; at least one member from HRSA's Office of Planning, Evaluation, and Legislation; and at least one member from a HRSA program bureau as follows: the Bureau of Primary Health Care, the Bureau of Maternal and Child Health, or the Bureau of Health Professions. In general, HRSA staff participated both in interviews related to their specific program area as well as those related to other program areas. Consequently, they were able to view programs that they were not involved with regularly.

MPR staff directed interviews for each research team; HRSA representatives participated by asking follow-up questions. Of the two research teams that visited each site, one generally focused on MCH issues, and the other focused on Ryan White and health professions training issues. Both teams collected information on CHCs. Teams were divided in this way to make the best possible use of MPR's experience in evaluating HRSA programs.

During the site visits, we interviewed multiple informants, including program directors and other program staff (Table I. 1). When possible, we interviewed informants from community-based organizations or providers that were subcontractors to programs. For certain programs, we also met with members of planning councils or consortia or observed meetings. The interviews were based on protocols developed for each target program and focused on several topics designed to address infrastructure building (see Appendix A). These topics include cooperation and collaboration, planning requirements, training, funding streams, and program responses to market changes. At the

TABLE I. I

SITE VISIT INFORMANTS BY PROGRAM CLUSTER

City	Program Cluster			
	HIV/AIDS	Maternal and Child Health	Primary Care	Health Professions
Boston	• Ryan White Title I Director and Chief Executive Officer for East Boston Community Health Center • Ryan White Title I Planning Council Representative-President Dimock Community Health Center • Ryan White Title II Director-Director of Client Services • Ryan White Title II Provider-Coordinator at Northshore AIDS Collaborative • Pediatric AIDS Provider-Staff of Dimock Community Health Center	• Healthy Start Director and Quality Assurance Manager • Healthy Start Project Director Martha Eliot Health Center • Healthy Start Consortium Meeting • Title V Representatives-Assistant Commissioner Bureau of Family and Community Health, Staff members Dimock Community Health Center • CISS Representative-Director of Policy and Programs in Maternal and Child Health-Department of Public Health • HRSA Coordinator/MCH Central Liaison to State Directors	• Executive Director, MA League of Community Health Centers • Chief Executive Officer for East Boston Community Health Center * Director, Dimock Community Health Center • Director Primary Care Office, Director of Primary Care Services • Community Health Center Providers, and Community Health Center Field Officer	• AHEC Representatives: Acting Director Boston AHEC; Associate. Director Boston University School of Medicine • Academic Health Center Representatives: Director of Medical Education/ Associate Dean of Student Affairs, Boston University Medical Center; Chairman, Office of Family Medicine and PI for Pre-Doctoral Family Medicine Program

TABLE I.1 (*continued*)

City	Program Cluster			
	HIV/AIDS	**Maternal and Child Health**	**Primary Care**	**Health Professions**
Cleveland	• Ryan White Title I Director • Ryan White Title I Provider-Director Infectious Disease Clinic MetroHealth Medical Center • Ryan White Title II Director Program Administrator, AIDS Client Resources • Ryan White Title II Provider-Executive Director AIDS Taskforce of Greater Cleveland • Ryan White Title II Consortia Meeting • Consortia Representative-Director of Services at AIDS Task Force of Greater Cleveland • Pediatric AIDS Provider • Ryan White Title I Planning Council Meeting	• Healthy Start Director * Healthy Start Provider-NEON Health Services • Title V Maternal and Child Health Representatives: Chief, Bureau of Children with Medical Handicaps and Chief, Bureau of Child and Family Health • Title V Provider and Co-chair for the Healthy Start Consortium • Title V Provider General Manager for Public Health Programs • Healthy Start Consortium Meeting	• Director, Primary Care Association • Director, Primary Care Office • CHC Provider-CEO NEON Health Services	• AHEC Director, Project Director Urban Area Health Education Center

TABLE I.1 (*continued*)

City	Program Cluster			
	HIV/AIDS	**Maternal and Child Health**	**Primary Care**	**Health Professions**
Phoenix	• Ryan White Title I Director • Ryan White Title I Provider-Executive Director AIDS Project Arizona • Ryan White Title I Planning Council Representative-Program Director HIV Care Direction • Ryan White Title II Director, Manager, HIV Planning and Services • Pediatric AIDS Provider-Nurse Coordinator, Phoenix Children's Hospital	• Title V Maternal and Child Health Representatives: State Title V Director; Chief, Office of Children with Special Health Care Needs; Bureau Chief, Community and Family Health Services • CISS Grantee • Title V Provider-Executive Director Southwest Human Development Title V Provider	• Primary Care Association: Executive Director, Arizona Association of Community Health Centers • Chief, Primary Care Office • CHC Provider-Executive Director, Mountain Park Community Health Center • Executive Director, Health Care for the Homeless • Clinic Administrator, Native American Community Health Center	• AHEC Local Contact-Director Institute for Health Professions Education • AHEC Director

end of each visit, we also asked HRSA study team members their views on the utility of the study methodology and on lessons from the experience.

C. STUDY SITE CHARACTERISTICS

Chosen for their geographic and cultural diversity (Table I.2), the three study sites also differed in their health care market characteristics (Table 1.3).

1. Boston

Boston is the largest of the three study cities. Its population of 4,306,103 is primarily white (62.8 percent), African American (25.6 percent), and Hispanic (10.8 percent) as shown in Table 1.2.

The Boston health care industry is critical to the city's economy as an important generator of jobs and revenue. Indeed, Boston is the home to many renowned academic medical centers and clinical programs that provide a high level of leadership in the community's health care market.

In the past, public health services were provided through an integrated system coordinated by the Department of Health and Hospitals of the City of Boston. The system included the Division of Public Health; the Boston City Hospital; Emergency Medical Services; CHCs (both HRSA funded and others), the Boston Specialty and Rehabilitation Hospital; and a variety of community-based organizations, hospitals, and other entities that provided health promotion, disease prevention, and treatment services through contractual agreements. In 1995, the city council and the Massachusetts legislature brought an end to the original structure of the public health system by severing the historical relationship between the Division of Public Health and Boston City Hospital, and, in the process, separated the locus of prevention and health promotion activities from the delivery of clinical services. A network of three new entities was created to address public health issues. 1) The Boston Public Health Commission oversees the delivery of population-based public health services

TABLE 1.2

POPULATION DISTRIBUTION OF STUDY SITES
BY RACE AND ETHNICITY

Site Characteristics	Boston	Cleveland Cuyahoga County	Phoenix Maricopa County
MSA Population	4,306,103	2,222,043	2,473,383
City Population	547,725	492,901	1,048,949
City Population Subgroups (percent)[a]			
White	62.8	49.5	81.7
African American	25.6	46.6	5.2
Hispanic	10.8	4.6	20.0
Asian, Pacific Islander	5.3	1.0	1.7
American Indian	0.3	0.3	1.9
Other	6.0	2.6	9.6

SOURCE: 1997 County and City Extra: Annual Metro, City and County Data Book. Sixth Edition. Bernan Press, Lanham MD 1997.

[a]Percentages do not add to 100 because the "White" category may include members of other ethnic groups.

TABLE I.3

HEALTH MARKET CHARACTERISTICS OF STUDY SITES

Health Market Characteristics	Boston	Cleveland	Phoenix	All MSAs with Population > 200.000
Percent Uninsured	10.0	12.0	18.0	14.0
Percent of Uninsured with No Usual Source of Care[a]	38.7	29.9*	48.9	42.3
Percent of Uninsured Who Had Difficulty Getting Needed Care[a]	27.7	35.9	28.4	29.7
Percent of Privately Insured Who Had Difficulty Getting Needed Care[a]	13.7	17.4*	17.2*	14.2
HMO Penetration	34.3	22.6	33.2	31.0

SOURCES: Cunningham, Peter, and Jeremy Pickering. "Uninsurance Rates Vary Widely Across Communities and Regions." Data Bulletin, Results from the Community Tracking Study. Number 5, Washington, DC: Center for Studying Health Change, Fall 1997; and Cunningham, Peter, and Peter Kemper. "Ability To Get Medical Care for the Uninsured: How Much Does it Vary Across Communities." Paper presented at the 1997 Annual Meeting of the Association for Health Services Research, Chicago, IL, June. HMO penetration data is from the InterStudy Competitive Edge, Part III: Leading Edge, June 1997.

NOTE: MSA = Metropolitan Statistical Area

"Adjusted for individual differences in health status, age, gender, family size, education, family income, race/ethnicity, and whether the interview was conducted in Spanish.

*Significantly different from all metropolitan areas with a population of over 200,000 at the .05 level.

in the city. 2) The Boston Medical Center, an academic medical center and private hospital corporation comprising Boston City Hospital and Boston University Medical Center, provides clinical care. 3) Boston HealthNet, an integrated delivery system of 11 CHCs addresses community-based health needs. The three entities have developed a strong partnership as well as linkages with other providers.

Boston HealthNet and other CHCs in the area play an important role in the public health safety net, which serves the 10 percent of Boston's residents who are uninsured. To serve the uninsured, CHCs receive a fair amount of funding from the well-financed uncompensated care pool. This pool is funded through hospital contributions that are proportionate to revenue from private payers. The pool also provides revenue for two major hospitals (Boston City Hospital and Cambridge Hospital) that serve a disproportionate share of uninsured and underinsured clients. In addition to serving the uninsured, CHCs are quickly becoming an important referral base for HMOs such as the Neighborhood Health Plan and Harvard Pilgrim Health Care.

Four academic centers--Harvard, Tufts, New England Medical Center, and Boston University--and their associated research. training, and clinical programs are the backbone of the health care health professions training activities in the area. The Boston Department of Public Health also plays an important role in providing field based training for a range of health care providers. The department also serves as a key participant in the development and implementation of the Center for Community Education, Health Research and Service, a unique collaboration with neighborhood health centers, and schools of nursing and medicine, designed to promote reciprocal training relationships between community-based health care settings and academic institutions.

Boston has a highly developed managed care industry. Its HMO penetration rate (34.3 percent) is the highest among the study cities (Table 1.3). Boston's commercial managed care market is

dominated by three not-for-profit plans: Blue Cross and Blue Shield of Massachusetts, Harvard Pilgrim Health Plan, and Tufts Associated Health Plan. In addition, Boston City Hospital and Cambridge Hospital have created a managed care plan for the uninsured. Until the state formally implements its expansion program to cover this population, the plan enrolls uninsured patients in a "shadow" managed care plan that provides the same services as those received by insured recipients. This assigns a primary care provider to uninsured patients and builds loyalty toward the hospital system. It also allows the hospital to generate utilization data on care-seeking behavior for the uninsured.

Several recent policy and financing developments will affect the dynamics of care for the uninsured in Massachusetts. Relevant to this study is approval given in May 1998 by the federal Health Care Financing Administration to the state's Children's Health Insurance Plan. This plan will expand Medicaid coverage for 26,000 children in families with incomes between 133 and 200 percent of the federal poverty line.

2. Cleveland

Cleveland is situated in Cuyahoga County, the state's largest and most densely populated county with a population of 2,222,043. Cuyahoga County is primarily white (49.5 percent) and African American (46.6 percent), with a small Hispanic population (4.6 percent). The health care market--considered to be strong, highly competitive, and dynamic--is driven by the city's leading hospitals and physician groups. Cleveland has a relatively effective safety net and indigent care system centered in the Cuyahoga County Board of Health (CCBH), the Cleveland Department of Public Health (CDPH), and MetroHealth. Consequently, Cleveland had the lowest percent of insured people without a usual source of care of all the study cities (Table 1.3). The majority of clinical

services are provided by MetroHealth, the county's public hospital system. Recently CCBH's role has shifted from that of direct service provider to community-wide health promotion and prevention efforts. The CDPH has primary responsibility for communicable disease prevention and control programs.

MetroHealth has a long history of serving the medical needs of the Cleveland community through patient care, research, medical education, and community service. Cuyahoga County makes significant financial contributions to MetroHealth, enabling the county to care for its growing share (12 percent) of uninsured persons. MetroHealth provides inpatient and outpatient services at the MetroHealth Medical Center, and neighborhood-based health services through its MetroHealth Clement Center for Family Care.

The percentage of privately insured people in Cleveland who have difficulty getting care is 17.4, which is significantly higher than in other metropolitan areas with a population of over 200,000 (average of 14.2 percent). In addition, Cleveland has a significantly lower percentage of uninsured people with no usual source of care (29.9) compared with Boston, Phoenix, and other large metropolitan areas.

Of the three sites visited, Cleveland has the lowest HMO penetration. The city's commercial managed care market is dominated by Ohio Blue Cross & Blue Shield, Blue Cross Anthem, Kaiser Permanente, and United Health Care. The Medicaid managed care market is dominated by Personal Physician Care and Total Health Care. However, since enrollment for AFDC eligibles in Medicaid managed care became mandatory in 1996, numerous new plans have entered the Medicaid managed care market.

3. Phoenix

Maricopa County, which includes Phoenix and its surrounding communities, contains more than 95 percent of the population of the Phoenix/Mesa metropolitan statistical area (MSA). The proportion of Hispanic residents (20 percent) is significantly above the national average. The rest of the population is primarily white (81.7 percent)‘, other (9.6 percent), and African American (5.2 percent). Despite Maricopa County’s reputation as a retirement community, the proportion of persons over the age of 65 is only slightly above the national average, although this may not reflect the seasonal migration of older persons into the area.

Phoenix, like Cleveland, has a high percentage of privately insured people who have had difficulty accessing care (17.2 and 17.4, respectively) compared to the national average of 14.2 for MSAs with more than 200,000 people. The percentage of people who are uninsured and having difficulty getting care is 28.4. In addition, almost half of Maricopa County uninsured residents report no usual source of care.

Public health services in Maricopa County are offered by three providers--the Arizona State Department of Health Services, the county government of Maricopa, and through prepaid plans serving the Arizona Health Care Cost Containment System (AHCCCS), the state’s alternative to traditional Medicaid. The Arizona Department of Health Services supports broad public health services throughout the state and in Phoenix. Maricopa County health services are provided through several agencies, the Maricopa County Department of Public Health Services, the Maricopa Department of Health Services, the Department of Environmental Quality and Community Services, and the Rabies/Animal Control Board, The Department of Health Services has primary responsibility, through the Maricopa Integrated Health System (MIHS), for providing primary care

‘This category may include some Hispanics.

services to county residents who are not eligible for the AHCCCS and who cannot afford commercial insurance. The MIHS provides comprehensive health care services through 13 primary care clinics, a 550-bed tertiary care hospital (Maricopa Medical Center), and a substance abuse treatment facility. The system also provides care to AHCCCS enrollees through the Maricopa Health Plan.

The AHCCCS provides services to low-income enrollees through participating managed care plans and a well-developed network of CHCs. A major source of funding for AHCCCS comes from the Tobacco Tax and Health Care Act. This initiative, which was approved by Arizona voters in 1994, provides funding for tobacco-use prevention, education, research, and health care services through an increased tax on tobacco products. The majority (70 percent) of the revenue generated from the increased tax is designated for AHCCCS to provide health services for persons eligible for Medicaid and for certain other low-income children. Twenty-three percent of this revenue is earmarked for education, 5 percent for research, and 2 percent for corrections.

Arizona maintains strict eligibility requirements for AHCCCS coverage. Residents who do not qualify for AHCCCS, and who cannot afford health insurance, use the Maricopa Integrated Health System (MIHS). MIHS provides comprehensive health care services through its primary care clinics, Maricopa Medical Center (a tertiary hospital), and a substance-abuse treatment facility.

Phoenix's health care market has a long history of managed care, as demonstrated by the city's requirement, in existence since 1982, that all AHCCCS recipients enroll in managed care. At 33.2 percent, the commercial HMO penetration is similar to that in other MSAs.

II. INFRASTRUCTURE DEVELOPMENT

HRSA programs are funded on the condition that they meet explicit programmatic objectives related to service delivery and implicit objectives related to infrastructure building. In this chapter, we describe what we observed on the site visits about how HRSA programs facilitate community infrastructure building. In particular, we focus on the following activities: developing and sustaining collaborative relationships, assessment and planning, and developing financial and human resources.

In addition to observing community-level activities to build infrastructure, we also explore the degree to which we could identify the infrastructure benefits of the HRSA programs we visited. These benefits, examples of which are summarized in Table II.l, are described in each section below. Where relevant, we also describe how market changes influence the ability of HRSA programs to build and sustain infrastructure.

A. DEVELOPING AND SUSTAINING COLLABORATIVE RELATIONSHIPS

Collaboration around health care issues is not a new phenomenon. What is new is that many grants now require agencies to develop formal mechanisms for facilitating collaboration with the communities they serve. Such requirements are in place for the Ryan White program, Healthy Start, CHCs, PCAs and Title V. In this study, we focus on the experiences of the Ryan White and Healthy Start' programs in developing such mechanisms, since HRSA requirements for community participation and representation are more clearly defined for these two programs.

TABLE II. 1

EXAMPLES OF INFRASTRUCTURE-BUILDING ACTIVITIES

Types of Activities	Example	Benefits
DEVELOPINGAND SUSTAINING COLLABORATIVE RELATIONSHIPS	Ryan White and Healthy Start program requirements support collaboration	❑ Enhances information sharing and shared decision making among key stakeholders ❑ Channels disparate efforts to ensure there are no overlapping services ❑ Shifting funds from Ryan White Title I to II increases continuity of care by ensuring the availability of HIV drug assistance ❑ Mobilizes grassroots participation ❑ Enhances ability to build trust among program recipients due to increased community representation and involvement
ASSESSMENT AND PLANNING	The Title V needs assessment/ comprehensive planning requirements encourage improved service delivery	❑ Promotes the integration of services with other programs to enhance service delivery (i.e., Mom-mobile, MCH/HIV services referrals of high-risk infants) ❑ Two local advocacy groups, spin-offs of Title V advisory groups. address adolescent and perinatal health issues; these groups also maintain a high level of interest in the community around MCH issues 3 Providers and parents affiliated with the Children with Special Health Care Needs program, providers and parents are a strong voice for children's health care issues ❑ Byproducts of process yield helpful tools (i.e., consumer handbooks. directories of services)
	Provider networks are encouraged by the planning process in Ryan White programs	❑ Needs assessments encourage more systematic approaches to targeting all resources for funding, not just HRSA ❑ Competition reorganized the provider landscape, expanding services to individuals not traditionally served 3 Providers of pediatric AIDS services developed partnerships with non-pediatric providers to create a new strategy to obtain funding for pediatric services 3 Title I funds used to cross-subsidize an additional nurse for an underfunded MCH HIV service, increasing treatment compliance

TABLE II. 1 (continued)

Types of Activities	Example	Benefits
DEVELOPING FINANCIAL RESOURCES	CHCs use HRSA funds to leverage other funds	Cl CHC receive state and local funds due to HRSA seed money, providing services for an additional 2,000 uninsured persons ❑ CHCs are able to provide more comprehensive care through a patchwork of funding that builds on HRSA funds
DEVELOPING **HUMAN RESOURCES**	HRSA health professional training grants encourage a workforce sensitive to the needs of vulnerable populations	❑ Exposes health professions students to safety net providers for and care tailored to vulnerable populations ❑ Students and trainees enhance ability of CHC to provide services to vulnerable populations, particularly through the NHSC ❑ Helps safety net providers and academic institutions to identify and recruit potential employees ❑ SPNS and other HRSA training programs support research activities at CHCs, allowing safety net providers access to cutting-edge treatment methods Cl Assists in building respect of family practice providers among other specialty providers in the community Cl Fosters the ability of health professionals to serve as mentors to high school and college students who, in turn, gain direct exposure and insight into the field

1. Building Collaboration Structures

Ryan White Title I grant award, grantees are to ensure that (1) there is a formal nomination process for membership on the planning council; (2) 12 legislatively defined membership categories are represented;' and (3) the composition of the council closely reflects the demographics of the HIV epidemic in the area, and (4) at least 25 percent of the council comprises people living with HIV disease. Ryan White Title II grant, grantees are required to periodically convene meetings among the following individuals: people with HIV, representatives of grantees, providers, and public agency representatives. The purpose of these meetings is to develop a statewide coordinated statement of need. The grant also requires the Ryan White grantee to consult with potential service recipients to determine appropriate models for service delivery.

Despite fairly explicit requirements regarding the composition and the duties of the Ryan White Planning Council, all three sites we visited experienced difficulties in forming the councils and in engaging them to work collaboratively. Phoenix and Boston planning councils have resolved some of their difficulties, and Cleveland, which is still in the early stages of developing its council, is grappling with these issues. In the following section we present observations on community collaboration and participation in Ryan White Title I planning councils and note which observations can also be applied to Ryan White Title II and Healthy Start consortia.

'Mandated categories of representation include the following: health care providers, including Federally Qualified Health Centers; community-based organizations serving affected populations; social service providers; mental health and substance abuse providers; local public health agencies; hospital planning agencies or health care planning agencies; affected communities, including people living with HIV or AIDS and historically underserved subpopulations; nonelected community leaders; state government representatives, including those from Medicaid agencies and Title II; Title IV grantee or representatives with a history of serving children, youth, and families with HIV; and other federal HIV programs.

We asked planning council informants to comment on collaboration among members and on their perception of the council's effectiveness in carrying out its mission. Informants from Boston and Phoenix councils reported that, unlike in the past, the planning councils are currently working collaboratively. Previously, councils experienced significant problems developing effective working relationships. In fact, HRSA intervention was required to reorganize both councils. Informants described the original councils as dysfunctional. There was considerable friction caused by turf issues and as a result of the council's lack of understanding about its mission and about how it should conduct its work. In addition, the original councils did not meet HRSA requirements for representation, the lines of responsibility and oversight were muddled, and there was a community perception that power rested in the hands of just a few council members. Today, the councils meet, or come much closer to meeting, HRSA requirements. While turf issues persist to some degree in both councils, they are not as prominent as in the past.

The Cleveland Ryan White Planning council, now only its third year, is facing many of the challenges faced earlier by the Boston and Phoenix councils. Informants in Cleveland echoed sentiments about several difficulties: clarifying the mission of the council, developing strategies for collaboration and for allocating and spending funds, and minimizing turf issues. While Cleveland council members do not believe they have yet entirely achieved effective communication and collaboration, it appears that most issues will be resolved as the council members continue working together.

In the process of becoming mature, Boston and Phoenix planning councils/consortia learned lessons about stimulating active participation and collaboration that could help other councils and consortia in the early stages of development. First, they reported that time and energy must be devoted to orienting representatives to the council/consortium and its activities. As one informant

commented, "The planning council is like a marriage; you have to meet, date, and get married." In this analogy, marriage represents a successful collaborative relationship. To achieve a "happy marriage," the planning council conducts periodic orientations and retreats to help new members get to know one another and learn how to work together. Second, the councils/consortia representatives suggested that members should receive training in leadership skills and in how to participate effectively in a formal meeting, since community representatives have varying levels of leadership skills and experiences. One consortium, recognizing that leadership and participation must be cultivated, specifically allocated funds to leadership training for its members. Councils/consortia with formal meeting structures based on parliamentary procedures considered training in "Robert's Rules of Order" to be key. In addition to keeping meetings running effectively, training also minimizes the confusion and intimidation felt by members who are not familiar with the rules. For example, at a formal council meeting we attended, we observed the evident frustration of a community representative who did not fully understand why he could not engage in further discussion on a motion that had been called for a vote. In general, knowing how to participate in formal meetings facilitates group interaction and decision making. Informants noted that HRSA could play a stronger role in providing technical assistance to, and in disseminating information among, grantees about the variety of strategies planning councils and consortia are using to facilitate collaboration and networking among their members.

Much like the Ryan White program, Healthy Start was conceptualized as a community-based initiative. To receive funding, projects had to organize a consortium made up of community members who would guide the planning and implementation of Healthy Start. In contrast to the Ryan White program, Healthy Start projects received less guidance from HRSA in terms of how to

structure consortia, leaving communities considerable latitude.* As a result, the consortia varied greatly from project to project. Boston has a large central consortium comprised of 300 members. in addition to several local (neighborhood-level) consortia. Cleveland has no large central consortium, preferring to conduct business in smaller committees and local consortia. Both models have had some success in involving community members, although both programs acknowledge some frustration in not achieving as high a "grass roots" participation as they would like.

In contrast to the Ryan White planning council and consortium meetings, the Healthy Start committee meetings we observed were less structured in terms of member participation and discussion. The Healthy Start consortia were also markedly different from the Ryan White councils/consortia in composition. The majority of people at the Healthy Start meetings we attended were outreach workers and representatives of consumer advocacy groups; many were minority group members. In contrast, the Ryan White council/consortia included a large number of white professionals, which is related in part to the concentration of HIV provider expertise in academic health centers.

Attempts at collaboration by Ryan White and Healthy Start councils/consortia also show that barriers related to culture, religion, and racism often appear in the process of trying to encourage racial and ethnic minorities to participate. While both the Ryan White and Healthy Start projects target populations with disproportionate numbers of racial and ethnic minorities, the Healthy Start projects we visited appear to have been somewhat more successful that the Ryan White programs in engaging minority members. This may be partly a result of differences in the target populations of the two programs. For example, one Ryan White planning council was having difficulty meeting

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'Howell. E., B. Devaney, M. McCormik, and Raykovich, K. "Back to the Future: Community Involvement in the Healthy Start Program." *Journal of Health Politics, Policy and Law*, vol 23, no. 2, April 1998.

the requirement that. 53 percent of its members be from the African American community. Moreover, the council recently reported that African Americans were not using Ryan White services at expected levels. It was suggested that trust issues, in part, contribute to this problem. According to one informant, the legacy of distrust left by egregious medical experiments on African Americans has deterred them from participating in new HIV drug therapy programs. The views of communities of faith on a particular issue were also found to influence African American's response to health concerns. It was suggested that including communities of faith was key to the participation of African Americans in health issues.

2. Collaboration Among HRSA Programs

As mentioned, most HRSA programs are required as a grant condition to collaborate with other agencies and organizations in the community, including other HRSA programs. Better planning, sharing of information, and efficient use of limited resources are some of the positive outcomes anticipated as a result of such collaboration. While conducting our site visits, we asked informants about the degree to which they collaborated with other HRSA programs.[3]

a. Collaboration Within the HIV/AIDS Cluster

We observed several indications of collaboration among the HIV cluster programs and benefits of such collaboration. Programs are motivated by a strong commitment to a common goal facilitated by the sharing of resources.

Collaboration in the HIV cluster is stronger between the two long-standing Ryan White Title I and II programs in Boston and Phoenix and less developed between Cleveland's Title II program

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[3] 'Collaboration within the health professions training cluster is discussed in Section II.D: Developing Human Resources.

and its fairly new Title I program. Linkages between Title I and II programs are particularly strong in Phoenix, in part because the Title I director previously served as the state director for Title II and so has a clear understanding of the goals of both programs and how they can work together to meet these goals. This was clearly demonstrated by the director's leadership in supporting the transfer of Title I funds to the Title II AIDS Drug Assistance Program (ADAP), which was facing a funding shortage and difficulty meeting client medication needs. The Title I director appears to maintain a strong working and personal relationship with the Title II program staff. In Boston, collaboration was made easier by the decision of funders and grantees to pool all HIV available funding in the area.

As noted, the newer Cleveland Ryan White Title I Program is still struggling to develop an effective relationship with Title II. Despite the fact that memberships of the planning council and consortium overlap, there appears to be a lack of communication between the two bodies. In some instances, the lack of communication and collaboration has resulted in duplication of efforts.

The extent of collaboration between the AETC and Ryan White programs varied. In Cleveland and Phoenix, the AETC and planning councils interacted primarily through council membership and continuing education programs for HIV/AIDS care providers. Councils contract with AETCs to provide education and training sessions to council members and local providers. However, in Cleveland, we were told that continuing education sessions were not well attended, and there were significant concerns about the topics chosen and quality of training sessions and about matching them with provider needs. In Phoenix, the Ryan White director pointed out that the AETC acts quietly and is almost invisible in the AIDS community; in fact, he himself admitted to recently "rediscovering the AETC." In general, we were unable to clearly determine whether the AETCs are structured to respond to the educational and training needs of practitioners in these cities. Poor

attendance at training sessions and questions about the appropriateness of the training topics selected by the AETC, however, point to missedopportunities by the AETC to clearly identify providers' educational needs and respond to them.

The collaborative relationship between Ryan White and the AETC in Boston is much stronger. This may be because the AETC representative is a "full partner" in council activities. The AETC representative leads one of the council's most active committees--the evaluation committee. Moreover, as in the other two sites, the AETC in Boston supports the council by providing it with information and training on key topics such as new federal guidelines for antiviral therapy and changes in drug treatment. In contrast to the AETCs at the other two sites, the Boston AETC is also externally visible and is much better known in the AIDS community. It recently collaborated with the local public health agency on an assessment of education and training needs in the Ryan White service area. Under the auspices of the state Medicaid program, the AETC conducted focus groups to examine the issue of unmet need and adherence to HIV treatment regimens among specific populations. The AETC's strong presence in Boston and its ability to respond to the needs of community providers appear to be related to its active participation on the council and to the fact that it works with other local and state agencies to assess training needs.

b. Collaboration Within the MCH Cluster

Title V programs are also required, as a condition of their grant, to use a collaborative process to develop goals and objectives, and to design programs. However, the structure for this collaboration is not specified. and there is wide variation in how the programs interpret and meet this requirement. The collaboration process is sometimes more intense when the Title V program is re-examined every five years as required by HRSA. We heard that, at this time, the state Title V staff usually convene one or more groups or committees to discuss program goals. However, this process

is generally not a regular one, nor does input from the community appear to drive decisions about program development. One interesting exception to the pattern is Massachusetts' move toward using local community health networks for Title V planning, although the process was still under development at the time of our visits.

On the whole, the Children with Special Health Care Needs (CSHCN) programs were described as being somewhat isolated from the Title V collaboration process in the sites we visited. However, there are some innovative efforts to link different funding sources (including funds from the Department of Education, Medicaid, and Title V) for the special needs population. Also, CSHCN programs are co-located with other Title V programs within a state's health department, facilitating collaboration.

Title V programs are not as closely linked to Healthy Start as one would expect given their closely linked goals and the common population served. Title V is generally administered by the state and Healthy Start is community-based, creating a more distant relationship than might be desirable. Nevertheless, there is usually a Title V presence on Healthy Start consortia. Also, Title V programs and Healthy Start have maximized funding opportunities for MCH programs in the two locations with Healthy Start (Boston and Cleveland) by using state Title V funds more intensively in areas of the state outside the Healthy Start project area. For example, Title V informants felt that the presence of Healthy Start had led to declined Title V funding in Cleveland. A side effect of this was a decline in funding for MetroHealth, the primary recipient of Title V funds, leading to some tension between that organization and Healthy Start.

c. Collaboration Within the Primary Care Cluster

In the primary care cluster, the extent of collaboration and synergy among the PCA, PCO, CHCs, and some health professions programs varied. These programs generally support each other

through very specific activities. For example, PCAs rely heavily on PCO shortage designations for obtaining CHC grants and placing NHSC providers. PCOs, on the other hand, rely heavily on PCA advocacy for primary care issues. In fact, one PCA lobbied to have the PCO created within the state health department. The collaborative relationship between CHCs and PCAs is captured in the name often given to PCAs: "the trade associations for CHCs." However, in Cleveland, we heard of tension among the PCA, the PCO, and CHCs. Coordination and networking among these programs was not optimal because CHCs function independently of the PCA and PCO. We were told that some of the tension between the PCA and CHCs was the result of disagreements about how to respond to the competitive local managed care environment.

d. Collaboration Across the Primary Care, HIV, and MCH Clusters

In general, we observed a much higher degree of collaboration within each of the program clusters (primary care, HIV, maternal and child care) than across program clusters. Cross-program collaborative relationships also differ across the three sites.

For example, in examining the collaboration between the HIV/AIDS cluster programs and the primary care cluster programs, we found such cross-site variation. Informants from the three PCOs we visited reported that they did not often collaborate with Ryan White programs. However, PCAs said they collaborated with the Ryan White program if member CHCs were involved as HIV providers, which was true for all three sites. At these sites, Ryan White funding was an important resource for expanding services to HIV-infected CHC clients, showing that sharing of clientele creates an opportunity for collaboration.

In Cleveland, HIV and primary care programs plan to work together to address the issue of underutilization of HIV services among African Americans. CHCs in Cleveland, which have a long-standing, solid reputation for providing culturally competent services, have gained the trust and

respect of the African American community. In contrast, the developing Ryan White program is struggling to attain the same level of trust and to increase the use of its services by the African American community. While CHCs have strong links to that community and serve some HIV clients, CHCs have not generally conducted outreach to increase HIV-infected African American's use of Ryan White services. The Ryan White Title I director told us that, in order to increase utilization of services in the African American community, an RFP to conduct outreach for Ryan White services in racial and ethnic minority communities was to be released soon. The director expects that CHCs will respond to the RFP with a strategy for using their relationship with the community to reach out to HIV-infected African Americans. In addition, the Ryan White planning council recently nominated a CHC staff member to the council to represent CHCs and to bring expertise on serving racial and ethnic minorities in the community.

Ryan White programs have also been successful in integrating their services with the services of programs in the MCH cluster. One Ryan White program enlisted the assistance of Healthy Start providers to conduct HIV testing in a Healthy Start-sponsored "Mom-mobile." While the Mom-mobile was originally designated to provide Healthy Start clinical and outreach services, it is now also used in HIV case finding and outreach.

Along the same lines, we heard about collaboration between MCH cluster and primary care cluster programs. Collaborative relationships between PCOs and MCH programs may be facilitated to some degree by the location of both programs in the same organizational unit in the state health department. However, despite this physical proximity, we did not find that the two programs often took advantage of opportunities for coordination in Cleveland or in Phoenix.

In Boston, the physical proximity of the two programs allowed staff to more often aggressively plan and coordinate services for children and adolescents within the CHC network--the main vehicle

for delivering primary care services. Boston also reported strong collaborative relationships between CHCs and Title V. The state health department unit that coordinates PCO and MCH programs also serves as the focal point for Title V funds and state funds to community health centers. Centralizing the coordination and disbursement role facilitates the use of Title V funds in CHCs.

In contrast, relationships between CHCs and Title V programs in Cleveland and Phoenix appear to be strained. Much of the tension is related to decisions about how Title V funds are used. As CHCs face financial pressures, they view Title V as a possible source of funding; however, in both places, Title V funds go to either support nonhealth services such as enabling services and population-based services or to entities other than CHCs. Tension between PCOs/PCAs and Title V programs also seems to be related to unsuccessful efforts by PCO/PCAs to help CHCs obtain Title V funds. In sum, strained relationships, poor collaboration, and the tendency of PCOs, PCAs, CHCs, and MCH programs to act in isolation appear to contribute to difficulties in routing the Title V funds to CHCs.

Collaboration between CHCs and Healthy Start has improved during the life of Healthy Start in Boston and Cleveland. However, some tensions related to competition for funding remain. In Cleveland, the Northeast Ohio Neighborhood Health Services (NEON), a large CHC network, received a substantial amount of money to serve as a subcontractor to oversee Healthy Start activities. Over time, it became evident that using clinical service providers to oversee neighborhood-based outreach activities was not as effective as anticipated. In the last year of the Healthy Start project, responsibility for overseeing these activities was shifted to nonprofit neighborhood-based organizations with a long-standing presence in the community. In addition, the scaling down of the demonstration phase of Healthy Start brought with it a significant reduction in the amount of funding going to CHCs for outreach and case management. CHCs are now struggling

to provide more targeted case management services within the diminished Healthy Start budget. NEON does maintain a contract with Healthy Start to reach out and provide services to women in jails.

In Boston, CHC participation in the Healthy Start program was not as central as initially anticipated by the CHCs. Initially, the PCA, as an advocate for the CHCs, participated in the development of the Healthy Start application. In return for assuming a lead role in the application, the PCA anticipated that the local CHC network would serve as the focal point for local Heathy Start activities, but this did not occur. After much debate, the H.S. consortium decided that the program should not be based in health centers. Currently, 15 CHCs receive some funding to provide enabling services under the program. In the eyes of PCA staffers, Healthy Start is ineffective as a service delivery program but more successful as an economic development program and as an exercise in the community involvement process. The PCA staff believes the focus and impact of Healthy Start would have been very different under a CHC model.

e. **Benefits of Collaboration and Partnerships**

Program requirements for collaboration help to mobilize community leadership around health issues. Informants for the Ryan White program told us that, the community participation and representation requirements legitimize and channel disparate efforts and create new partnerships around certain health issues. In the late 1980s, a variety of grassroots advocacy agencies and organizations blossomed in response to the AIDS epidemic. Often, these agencies worked independently and provided a variety of often overlapping HIV services. The Ryan White program, authorized in 1990, was a latecomer to the HIV service delivery scene. Thus, it did not always serve as a catalyst for community activation in the cities that had been hard hit in the early days of the epidemic, although in one place we visited, it did reactivate dormant groups. The Ryan White

program brought these disparate groups "to the table," helping to legitimize community concerns and better channel existing efforts. For example, at one site, an HIV advocacy group that often used adversarial strategies to draw attention to HIV issues was made a formal subgroup of the council. Instead of working against the council, the group now works in an organized and constructive manner to address HIV issues from a consumer perspective. As one informant commented, "There is no other forum in the community outside the council that can get community stakeholders talking to each other, brokering services, and collaborating."

Healthy Start in Boston and Cleveland is also a catalyst for grassroots participation around the high rate of infant death and other problems facing young families. While CHCs and public health providers have addressed infant mortality and maternal and child health issues, few grassroots organizations were involved before the Healthy Start demonstration was funded by HRSA. In Boston, Healthy Start brought together more than 70 different community-based groups including tenant organizations, shelters, nonprofit groups, health centers, and others to provide a wide array of services intended to directly or indirectly reduce infant mortality. Services range from adult education, career development, domestic violence intervention and training, and instruction in English as a second language to pregnancy and parenting support, smoking cessation classes, and nutritional support. Cleveland Healthy Start also employs a large network of community-based organizations--the Urban League, "settlement house" agencies, and churches--that help the program conduct outreach, health education, or social services.[4]

Advocating for the interests of mothers and children is an important spin-off of Title V infrastructure-building activities. We observed several indications that HRSA programs play or have

[4]A separate evaluation of the impact of the Healthy Start Program is being conducted by MPR. The final report from this evaluation is expected in March 2000. Several interim reports have been produced.

played a role in giving vulnerable populations a voice in the community. In Phoenix, we were told that two local advocacy groups--an adolescent health care coalition and an entity focused on perinatal health issues developed out of Title V partnerships. The providers funded through Title V programs, especially those funded through the Children with Special Health Care Needs programs, also form a strong advocacy group for children's health issues, as do parents of children served by these programs. The activities of these provider and parent groups, and those of other local advocacy organizations, seek to maintain a high level of interest in the community around MCH issues. We also learned that the PCAs in Phoenix and Boston play a significant role in promoting primary care issues. The Arizona PCA successfully advocated to appropriate a substantial portion of new state tobacco taxes to CHC services. These funds will be used for aggressive outreach, to expand services to uninsured persons, and to enhance CHC services. They expect that CHCs will be able to serve up to 2,000 uninsured persons with funds obtained from this source.

Primary care advocacy activities were also described as fulfilling an important infrastructure-building function in Boston. The PCA was consistently described by informants as "very effective and skilled at moving the CHC agenda forward." The PCA is involved in many collaborative arrangements and represents CHCs on many state and local committees that address primary care, financing, and other health issues. For instance, it has pioneered the development of strategies to ensure that CHCs will be competitive in the changing health care marketplace. To this end, it was instrumental in establishing the first HMO comprising CHCs and in assuring a substantial market share of clients for the centers. Today, the plan serves as a promising model for other CHCs.

In summary, despite the difficulties associated with developing collaborative relationships, HRSA requirements have for the most part positively affected communication and information sharing. Providers who participate in HRSA councils and consortia develop a better appreciation

of what other providers are contending with and are thus better able to help them. Councils and consortia provide consumers with an opportunity to make suggestions and learn about service networks and changes' in services and programs. For HRSA grantees, formal mechanisms for participation ensure that key community stakeholders are included in the planning and decision-making process, and that community support for the program is developed.

B. ASSESSMENT AND PLANNING

Determining the direction that HRSA programs should be taking at the community level entails evaluating community health needs, the existing service delivery system, and human and financial resources. Consequently, most HRSA programs must provide a needs assessment as part of the grant application or to meet a comprehensive planning requirement. To meet this requirement, grantees are generally directed to (1) establish a process for identifying the services needed in their community, (2) develop a comprehensive plan for an organized delivery system of health services that is compatible with coexisting state or local plans for the delivery of related services, and (3) establish priorities for allocating funds in the eligible area. Informants report that these activities have several spin-off effects that improve service delivery to underserved populations. Important among these effects are a systematic approach to resource planning and the reorganized provider landscape that results from competition created through the planning process, as described in the following section.

1. Needs Assessment

HRSA programs conduct their needs assessment in one of two ways. Under the first scenario, the grantee administrator conducts the assessment with input from subgrantees and other community members. Subgrantees told us that, under this approach, they are not heavily involved in conducting

the needs assessment but that they respond to grantee activities by providing relevant data or by commenting on documents. Under thksecond scenario, the grant administrator contracts out the entire needs assessment or large portions of it. For example, in both Boston and Cleveland, Ryan White programs contract out the needs assessment to researchers at local universities that have ties to the community. In Boston, contracts for extensive surveys and focus groups have also helped staff develop information on gaps in service delivery.

Both scenarios appear to help grantees meet their needs-assessment requirements. However, some people who worked under the contracting scenario criticized or questioned the contractor's experience with the population to be served. It appears that council members and subgrantees must be very comfortable with the qualifications of their contractor in order for this scenario to work.

Information gathered as part of the needs assessment does not always appear to serve as a building block for other planning activities. For example, information is informally shared with relevant partners but very rarely with other planning bodies or programs. Also mismatched timelines for data reporting and the geographic boundaries of service areas may result in a needs assessment that is not useful to another program or partner. Some byproducts of the needs assessment process, however, appear to be extremely useful to others. For example, handbooks and directories of HIV services in the community have helped HIV/AIDS consumers in identifying potential service providers.

2. Resource Planning

Comprehensive planning requirements for HRSA programs generally include a process for translating information from the needs assessment into a service delivery plan with priorities for allocating program funds. Planning committees or subcommittees often establish these priorities and identify service gaps. Then, under many grants, a competitive grant solicitation process is used to

distribute funds to community agencies according to the priorities and objectives outlined in their service delivery plans. This link between the planning and contracting process was implemented by most of the Ryan White, Healthy Start, Title V, and other MCH programs that we observed, thus tying the planning process for HRSA programs to direct service delivery in these communities.

Program staff often described the process of building consensus around goals and priorities as difficult. However, most informants reported that this process allowed them to maintain their program focus, make objective funding decisions, and facilitate decision making around emerging issues. Some grantees, however, considered the democratic process to be too rigid, and believed that it created significant competition among subgrantees. Informants in Phoenix were particularly vocal about how decision making based on the democratic process can result in unhealthy competition that impedes collaboration. For example, pediatric AIDS service providers told us that infants and children were at a competitive disadvantage for program funds because they are few in number, and they represent a small proportion of total cases. Advocating for funds for these children is particularly difficult because only one pediatric AIDS service provider sits on the planning council, making the planning process largely adult focused.

Planning activities under the three Title V programs we observed also are systematic, but they differ from those under Ryan White programs and vary among the three sites. Most Title V planning activities are conducted by state level staff who rely on the HRSA-MCH pyramid model to guide program objectives and funding priorities. This model shifts Title V's emphasis from clinical to population-based and enabling services. In Boston, Title V funds are generally allocated through a competitive grant solicitation facilitated by local community planning groups. In Cleveland, funds are distributed to counties according to a formula. Counties are required to have local planning groups decide on the further distribution of these funds. In Phoenix, Title V funds are dispersed

through a periodic competitive bidding process. In Boston, using local community planning groups to determine funding priorities appears to be on the road to incorporating more systematic grass roots community input into the planning process, but it is too early to determine the role these community planning groups will play in ongoing planning efforts.

Competition among subgrantees can be a result of planning, when the process identifies duplicate services. From one informant's perspective, duplication of services may be positive because it engenders competition, efficiency, and higher-quality products, and it provides consumers with choices. However, duplicate services also means increased administrative costs, which are difficult to cover under constrained budgets. Thus, budget pressures often force the elimination of duplicate services, and result in decreased consumer choice.

3. Improved Services Through Assessment and Planning

Through the formal mechanisms for collaborating, assessment, and planning, opportunities for improving service delivery are often identified. Here we describe some examples of how the assessment and planning process has led to improved coordination and delivery 'of services in the three sites that were visited.

The Ryan White program assessment and planning process improved the coordination and integration of services in several ways. For example, in Cleveland, Ryan White I funds are used to cross-subsidize human resources in a new underfunded women's and children's HIV service. This new service shares an adult clinic nurse supported by Title I funds. This sharing of resources improves follow-up care for women and children and increases treatment compliance rates.

In Phoenix, three large community programs offered the same family services for HIV-infected clients. Two of the organizations merged to ensure their survival. The third organization identified a need for family services which it now fills, serving communities composed of racial and ethnic

minorities and children. In this case, budget constraints initially stimulated competition among the three organizations, but the planning process reorganized the provider landscape and expanded services to individuals not traditionally served by the delivery system.

In an example from the MCH cluster of programs, CISS funding is used to support local planning agencies in Boston. The planning group convenes a network of providers and advocates for services for high-risk infants and children. In addition to planning and advocacy, this groups also implements an identification and referral system whereby a provider visits all families with high-risk infants at least once for screening and assessment.

We also observed counter-examples, where service delivery was undermined because of poor collaboration. At one site, for example, ineffective collaboration between Ryan White Title I and II providers resulted in duplicate case management efforts and confusion among providers. Both programs had developed their own case management models and training requirements, which differed enough to confuse case managers. Poor collaboration and communication occurred despite the fact that representatives from both programs were involved in needs assessment and planning. Apparently, effective communication had not occurred around case management issues.

C. DEVELOPING FINANCIAL RESOURCES

In addition to conducting needs assessments and planning, HRSA programs must find a way to sustain program activities when federal funding declines or ends. Moreover, HRSA is usually not the sole support of a program, so garnering other funds is essential for operations. For example, the HRSA grant is usually only about one third of a CHC budget. This aspect of infrastructure development may be formally required, in that some programs must match federal funds. In

addition, some programs (e.g. Healthy Start) have developed explicit strategies to address decreases in federal spending.

1. HRSA Grants as Seed Money

While HRSA is not usually the sole funder of the services, it substantially facilitates the development of the service infrastructure by providing grants that are matched formally or informally by other funds, including direct reimbursement for services by Medicaid. There was general consensus among informants in the three cities that HRSA funds are invaluable seed money. HRSA funds are particularly important when program staff approach foundations and public and private agencies for funding, since these agencies are often reluctant to support start-up activities but will support extensions of ongoing projects. In such cases, HRSA funds and program activities support core services that are maintained or expanded with other funding.

CHCs are a good example of how HRSA programs use their HRSA grants as seed money to develop a health care infrastructure in underserved communities. In all three cities we visited, CHCs provide services through a patchwork of funding sources that includes the following HRSA programs: health professions; Title V; Healthy Start (two sites); Ryan White Titles I, II, and III (two sites); and SPNS. Funding for CHCs also comes from other federal sources (Head Start, Substance Abuse and Mental Health Services Administration) as well as state and local sources. A CHC informant at one site told us that the center had become a 330 grantee, in part to avail itself of other HRSA funding opportunities in order to better serve its clients. For example, that particular CHC's HIV program relies on various funding sources, including Ryan White Title I and II, SPNS, and state grants. Without these funds, the center could not provide the level of comprehensive care it currently offers to HIV-infected clients. At another site, HRSA CHC funds are critical for meeting eligibility requirements for applying for and receiving state funds from a new tobacco tax fund

dedicated to expanding primary care services. These funds are available exclusively to already-established CHCs.

2. Sharing Funds Among HRSA Programs

Ryan White programs provide examples of how HRSA programs have sought to share their funds to effectively serve HIV/AIDS patients. At all three sites, we were told that the increased use and effectiveness of new antiretrovial medications has posed new challenges for the Ryan White program. Principally, these challenges include increasing per-person medication costs, increased use of services, the quick depletion of Title II AIDS Drug Assistance Program (ADAP) funds, and unmet client needs. Having acknowledged the fact that meeting clients' needs for medication is a priority, planning councils at all three sites voted to yield some portion of their Title I funds to support the Title II ADAP program. Most Ryan White Title I informants we spoke with believe that the shift of Title I funds has contributed significantly to continuity of care for many individuals with HIV/AIDS.

Overuse of ADAP funds at one site also led to additional strategies for ensuring more effective use of these funds. In general, Ryan White funds may not be used to provide services that are payable by third-party payers, including Medicaid, Medicare, and/or other state or local entitlement programs. In light of the quick depletion of ADAP funds, the program needed to ensure that funds were not used to pay for services covered by other programs. So the program created a work group to identify how other funding sources could be tapped before organizations sought reimbursement from ADAP. The product of the work group was a new screening form and resource guide for case managers to use in assessing clients' eligibility for drug reimbursement under other public programs. As a result of this guidance, expenditures for ADAP have fallen, and the program is now the payer of last resort.

The limited amount of Title I funds allocated to pediatric AIDS has prompted providers in Phoenix who serve children with this "illness to collaborate with other providers in the Phoenix community to develop a grant application for Ryan White Title IV funds. The applicants seek to address complex service delivery challenges by creating a system for linking pediatric AIDS services to HIV services for female adults.

One site has pooled all HIV funds available from the state, the city, and the Ryan White program. A single application meeting all state, city, and federal requirements is used to access these pooled funds. Funds were pooled so that they could be used more efficiently and to reduce applicant burden. Under the single RFP, there is one statewide consolidated statement of need, and grantees are held to one set of reporting requirements. The pooling of funds also reflects the philosophy of the program, which is to develop a seamless system of care.

3. Changes in Program Focus

Leveraging HRSA funds to obtain additional funding can also significantly change a program's focus or visibility in the community. It is unclear whether a change in program focus is a positive consequence of leveraging HRSA funds. On the one hand, a change in program focus may shift resources from one population to another, meaning that services are diminished for some groups. On the other hand, the change in focus may emerge as a positive response to changing community needs and may, at a minimum, assure a continued flow of funds into the community.

For example, Healthy Start sites lost much of their original funding as the program moved from the demonstration to the continuation phase. This rapid loss of revenue stimulated programs to develop strategies for sustaining their activities. Such strategies have focused primarily on developing partnerships or relationships with other public and private funding sources and programs in the area to assure a continuation of core activities. For example, in Boston, foundation funding

was obtained to support Healthy Start administrative staff. However, there also have been negative consequences to this loss of federal funds. First, it has been impossible to replace all of the dollars lost from the demonstration phase, and programs have had to substantially scale back activities. Also, while new funding sources will help sustain some of the original Healthy Start project activities, new funders may emphasize goals that differ from the goals of the original funders.

For example, one Boston CHC Healthy Start grantee managed to sustain a home visiting program for high-risk families by pooling Healthy Start funding with two similar state-funded efforts. While the original Healthy Start home visiting program was sustained, albeit at a lower level, the focus of the program shifted away from Healthy Start-eligible women to women who only meet the more narrow eligibility criteria for the state programs.

The risk programs face when leveraging HRSA funds is also illustrated by the experience of an AHEC program that lost its identity. The federal AHEC program provides five to six years of core funding to AHEC programs. AHECs generally seek state and other sources of funding to maintain the program after federal funding expires. According to one informant, the termination of federal funding and the loss of continued state funding at one site meant that "we had to give away the AHEC in order to save it." In the process of trying to survive, the program lost its presence. According to the AHEC director, the loss of funding required that the program meet its AHEC objectives under the auspices of a new 501(c)(3) corporation--Institute for Health Professions Education. This new corporation blends AHEC and AETC funds to provide training in selected areas of health professions and HIV. As a result of defunding and in the interests of the new leadership, it is less active in placing NHSC students, as many traditional AHECs do. This organization now seeks to play an important role in providing education in seven areas--aging, chronic diseases, cultural diversity, family violence, HIV/AIDS, social-cultural issues in health care,

and women's issues. As a result of this radical change in direction, there is a sense among local providers that the AHEC no longer exists. When we queried other community informants about the AHEC and its activities, we were consistently told that it had been defunded and that the informants were unaware of what it was currently doing. It is unclear whether this perception is related to the loss of funding and to the shift in emphasis to training activities or to the AHEC's new identity.

In marked contrast to the AHEC experience, one CHC reported that HRSA funds and associated grant requirements have helped it to maintain its identity and function as a community provider. The CHC is situated in a market where health care delivery systems are becoming more and more vertically integrated and competitive. In fact, several noncommunity-based hospitals and health plans have asked the CHC to join their delivery systems. The CHC has been able to resist these overtures to integrate by invoking the HRSA 330 grant requirement that CHCs maintain a community-based philosophy and certain structural and organizational requirements such as the creation of a community board. These requirements are difficult for most hospital and health plans to meet.

D. DEVELOPING HUMAN RESOURCES

HRSA programs focus on a wide range of health care issues affecting vulnerable and underserved communities. Thus, in addition to support of academic programs, HRSA's service delivery programs are excellent vehicles for community based training for health professionals, since they provide access to traditionally underserved populations and populations with complex health care needs. We found strong relationships between HRSA training programs and CHCs, but fewer such relationships between HRSA training programs and other HRSA programs. Such relationships provide benefits both for those who conduct the training as well as those who receive it. CHCs that serve as training sites increase their capacity to provide services to vulnerable populations while

creating for themselves an opportunity to identify potential employees from among those they train. The benefits to students include an insight into practice in a setting serving vulnerable populations and exposure to mentors who practice primary care.

1. Health Professions Training Programs and CHCs

HRSA health professions training programs and CHCs are partnering to ensure that physicians get experience in community-based settings and that patients receive quality care. For example, Boston University School of Medicine has received HRSA health professions training grants to establish the Department of Family Medicine and to conduct predoctoral training. Both grants were established in large part to facilitate the connection between faculty, students, and the broader community. The university's programs have forged collaborative relationships with two health networks. One is a formal partnership between the medical school, its affiliated hospitals, and eight closely affiliated CHCs. The other is a network that includes 12 CHCs, a college of nursing, and a teaching hospital. Both networks make it possible to conduct interdisciplinary training in the community. The residency program's first group of residents is expected to arrive this year, and the predoctoral training program is expected to provided clinical experiences at CHCs for about one-third to one-half of the school's medical students. People from the family medicine training program believe that HRSA training grants were instrumental in giving family medicine a foothold in the community's hostile, specialty-oriented atmosphere. As one informant put it, "One needed to be a pioneer to do family practice in the community just a few years ago." Today, family physicians are viewed as key members of community-based systems of care.

This relationship between academic medicine and CHCs was influential in recruiting a major national figure to the Department of Family Medicine. The CHC aggressively supported the

candidacy of this person and showed its commitment to serving as a partner in training. These academic connections have helped the Boston CHCs recruit new physicians.

Collaboration extends beyond health professions training to research. Two CHCs approached the Department of Family Medicine about collaborating on population-based research problems. The department will serve as the research administrative arm for the CHCs. There are plans to enlarge the current research agenda and develop a broad-based research network among CHCs to investigate the health problems of vulnerable populations.

The Department of Family Medicine also collaborates with a health plan to ensure continuity of care for plan members. Department clinical staff have agreed to coordinate care for plan members who are inpatients at the teaching hospital. Under this arrangement, a clinical staff member serves as the member's private attending physician. At discharge, the member is referred back to his or her primary care practitioner. This arrangement ensures that members will not be diverted to physicians who are unfamiliar with their health care needs, a common problem that disrupts continuity of care for patients admitted to teaching hospitals.

2. AHECs and Other Health Professions Programs

AHECs are designed to address primary care shortages in communities by linking the health care needs of communities with the resources of large academic centers. AHECs carry out their mission, in part, by supporting the development of primary care training programs and connecting these training activities to the community. For example, the Boston University School of Medicine AHEC was instrumental in solidifying the position of the new Department of Family Medicine in the School of Medicine and for laying the groundwork for HRSA training grants and other

foundation grants (Kellogg and Robert Wood Johnson Foundation grants)‘. The Boston University School of Medicine AHEC supports medical undergraduate and graduate training, and the Boston AHEC supports mentoring programs in health professions for high school students. Although these are separate AHEC programs, they work jointly to support health professions training goals in the community. Specifically, the Boston AHEC builds on the professional and physical resources of the Boston University School of Medicine AHEC to support many aspects of its health careers programs. For example, students from the Boston public school system who participate in the Boston AHEC’s Summer Enrichment Program receive academic support through an after-school program staffed by mentors from the Boston University School of Medicine. The Boston AHEC also offers an intensive eight-week academic experience for high school juniors and seniors interested in pursuing allied health careers through the Health Career Opportunity Program (HCOP). To conduct these activities, AHEC program staff built an ‘elaborate network of public schools, colleges, the Boston University School of Medicine and other medical institutions, the public health department, and others. The HCOP did not receive continued funding during the last application period. At the time of our visit, program staff were struggling to maintain the network but were optimistic about obtaining funds in the next application cycle. However, if additional funding is not received, it will become difficult for the program to sustain the partnerships it has forged.

The Phoenix AHEC, as mentioned, has lost its community presence as an AHEC. However, it continues to work closely with the Arizona College of Medicine and with local medical centers to provide community-based training for students.

‘Features of the Kellogg Community Partnership Program and Center for Community Health Education, Research and Service grant include community participation in the educational process, interdisciplinary teaching, and continuity of student experiences in family medicine sites in the community. The RWJF Generalist Physician Initiative grant supports the Center for Primary Care at the School of Medicine.

The Cleveland AHEC was once based at Case Western Reserve School of Medicine. The program was defunded several years ago because it shifted control from its community-based agency partner, as required by HRSA, to the medical school. According to the AHEC informant, the partnership requirement had created many problems for the program. As an urban center, the AHEC program found it very difficult to establish and maintain successful relationships with the community partner and the medical school. The medical school questioned the need for the investment in additional space and staff when medical school property and staff were available in the same community to run the program. Relationships eventually became so tense and fragmented that, after initial core funding expired, Case Western continued limited AHEC activities without a community partner.

Not surprisingly, two HRSA training initiatives have found common ground. The Boston and Phoenix AHEC sites are affiliated with the AETCs, which disseminate the latest in HIV/AIDS therapeutic and caregiving information to practitioners in the community.

3. Health Professions Training and Other HRSA Programs

The NHSC is a training program in the sense that it uses student financial aid as an incentive to share careers toward community-based medicine. At the same time, it is very much a placement program for underserved areas. There is a general consensus among PCO and PCA informants at all three sites that the NHSC program is instrumental in increasing access to services in underserved communities throughout the state, and especially in rural areas.

The perception of the importance of NHSC providers is more mixed in the three CHCs where we discussed NHSC issues. For example, the Boston CHC, while considered eligible to receive NHSC providers, has been able to recruit and retain other primary care staff and consequently it has not recently requested NHSC providers. In Cleveland, the CHC we visited had once heavily used

NHSC providers, but to&y the need is less acute because the center has lost a considerable number of clients to managed care. Also Cleveland CHC informants expressed general disappointment with the poor retention of NHSC physicians in the past. Over the years, few physicians have decided to remain at the center after completing their obligation period. CHCs have had more success retaining certified nurse midwives. Currently, the center has two midwives that are obligated through the NHSC program, but has been able to hire an additional certified nurse midwife, who has completed her NHSC obligation.

In Phoenix, NHSC providers are a key part of the provider network, and the NHSC plays an important role in helping the Phoenix CHC to recruit clinicians. In particular, the loan-repayment component of the NHSC program has proved to be a major recruiting vehicle. At the time of our visit, the health center director believed the center's future access to NHSC providers was in jeopardy because it is located in a health professional shortage area that may lose its designation as an underserved community. If this happens, the health center director believes that the center could lose a significant number of NHSC providers. This loss would cripple the center's ability to provide services to its primarily low-income Hispanic population. We were also told that, as in Cleveland, it is becoming more and more difficult to retain providers.

Provider recruitment and retention is difficult because there is competition from private health plans. Providers often view CHC facilities as relatively undesirable practice sites. For example, the centers are often in areas that have high crime rates. Recruiting staff to CHCs and training them is also difficult because these positions pay less than positions in both fee-for-service private practice and in large health plans. In Boston, however, the strong relationship between the family medicine training program and CHCs has made it easier to recruit physicians to CHCs. For instance, two physicians were recently hired after a six-week search compared to the typical two-year search

period. Other practitioners have been somewhat easier to recruit and retain than physicians. For example. the CHC in Cleveland was able to expand its staff of certified midwives by hiring a midwife who recently completed her NHSC obligation at the center.

Ryan White and MCH program informants generally knew less about HRSA health professions training programs than CHC informants. There is an exception in Boston, where we observed strong linkages between one CHC and the Ryan White SPNS program. Through the SPNS grant, the center is developing a model by which to integrate mental health and substance abuse services for HIV clients within a primary care model. The CHC is also an important training site for undergraduate medical and nursing students and for medical graduate residents. During training at the site, students learn about and participate in the new HIV-client service delivery models that are the focus of the SPNS grant.

An important spin-off effect of HRSA training programs is better access to care for vulnerable populations in the community, since, in addition to providing training experiences for its students, clinical staff provide direct services to the community. For example, in Boston the Department of Family Medicine employs eight family physicians in an outpatient department that primarily sees Medicaid recipients and uninsured patients. The department also allots a half day per family physician for community outreach and activities targeted to high-risk populations. Arrangements have also been made for staff to provide clinical services to a program for the homeless, and plans are underway to serve two HIV programs.

III. MARKET CHANGES AND THE CHALLENGES FACED BY HRSA GRANTEES

Changes in the health care market were in the forefront of each site visit. Although we asked questions about such changes and about how they have affected HRSA grantees, we also received much unsolicited input because of the pervasive influence of these changes. This chapter discusses what we observed to be the major changes that have affected HRSA grantees:

- Shifts in the demographic and political landscape
- The evolution of Medicaid programs
- Restructuring of providers through consolidation and vertical integration
- New technology
- Effects on infrastructure development

A. SHIFTS IN THE DEMOGRAPHIC AND POLITICAL LANDSCAPE

HRSA programs operate in a changing demographic and political environment that is beyond their control but that seriously affects their programs. Demographic shifts include:

- An aging population, resulting in fewer children per capita
- The movement of some low-income and minority populations traditionally served by HRSA from central cities to suburbs
- An increase in the number of uninsured people, including influences of Hispanic populations and other immigrants

As the populations traditionally served by HRSA change, the programs must adapt. For example, the population served by one Boston health center has become almost 100 percent Dominican in recent years, resulting in the need to add staff who speak Spanish and are aware of

Dominican cultural norms surrounding health care services. In addition, American Indians in Phoenix are increasingly moving from reservations into the city, making it necessary for programs to employ people who are sensitive to their health care needs.

The political environment is also changing. One associated trend is that state and local governments increasingly contract for many state-sponsored services. As a consequence, there is competitive bidding for services and a need for mechanisms to assure financial and program accountability.

Welfare reform is another major change, the effects of which are only now being felt. Those leaving welfare may lose their Medicaid benefits, resulting in more uninsured individuals who need services. It appears that the safety net provided by HRSA programs such as CHCs will be very important for these people. Still, this is not completely clear yet, and the extent to which CHCs fill this need will certainly vary from place to place.

B. THE EVOLUTION OF MEDICAID PROGRAMS

It is probably safe to say that the most profound market changes recently 'affecting HRSA programs have been changes in the Medicaid program. Fee-for-service reimbursement has been gradually replaced by managed care--both by primary care case management and, more recently, by fully capitated reimbursement. Another major change is the expansion of Medicaid for pregnant women, infants, and children. Managed care programs, in which Medicaid-covered individuals must select primary care providers, may or may not include HRSA-funded providers potentially reducing the Medicaid revenues of such programs. At the same time, the demographic changes mentioned above have resulted in an increasingly uninsured population seeking to be served by HRSA programs. While this is a return to the situation that existed in the 1970s, it is a retrenchment in

funding for many programs (such as CHCs) that have come to rely on Medicaid funding in the 1980s and 1990s.

The consequences of these changes are positive for some programs, negative (indeed dire) for others, and negligible for still others. For example, Healthy Start and Ryan White programs have not experienced a major impact from market changes. Healthy Start in particular is not as greatly affected as more clinically-oriented programs such as CHCs and some Title V programs, since many of its services and the programs it sponsors (e.g., support services) are not covered by Medicaid. Similarly, many Ryan White services are nonclinical. The exception is drug therapy, but most clients served by ADAP programs are uninsured, so there has not been a traditional dependence on Medicaid to cover those services.

The mission of the Title V programs has changed with the Medicaid expansions for women and children, and state programs are intensively redefining their roles in the new environment. In particular, they have struggled to have a significant involvement in the political process of defining the parameters of each state's child health insurance expansion program.

As primary care providers for many low-income people, CHCs have also been greatly affected by Medicaid changes, especially by Medicaid managed care. The degree to which a center is affected is quite variable, depending on how successful a center is in becoming a part of a network. For example, several CHCs in Ohio are suffering financially for two main reasons. First, their overall caseload has declined because of the demographic changes described above and because their patients have chosen other providers. Second, their caseloads have become increasingly made up of uninsured people. In contrast, other Ohio CHCs have joined networks and maintained their caseloads, and consequently have done well.

A specialized aspect of Medicaid managed care is the mental health carve-out process. The homeless grantee that we visited in Phoenix is especially affected by this process. The grantee has had great difficulty obtaining mental health and substance abuse services for its clients. Without becoming a direct provider in the carve-out plan (a difficult process), it is impossible for this grantee to obtain services covered by Medicaid.

We observed diversification in the mission and role of some CHCs in response to Medicaid changes and the declining size of their HRSA grants. They have had to find other sources of funds, such as Ryan White grants, Head Start (making them child-care providers), and SAMHSA (through providing mental health/substance abuse services). The change in the source of their funds has shifted the emphasis of some centers away from primary care.

C. RESTRUCTURING OF PROVIDERS

Another market change that has affected HRSA providers is the increasing consolidation and vertical integration of some health providers. The rate of this change varies from site to site. Boston is experiencing the most profound changes as its many major medical centers consolidate into a smaller number of larger entities. CHCs have traditionally enjoyed a very'favorable relationship with these medical centers. (The CHCs use physicians and other providers in training and get other direct financial subsidies.) It is unclear how the restructuring of providers will ultimately affect the centers, since many of the changes are fairly recent. For now, most CHCs seem to be holding their own.

In addition to CHCs, public hospitals have been affected in various ways by changes in provider structure. To one degree or another, the fate of public hospitals also affects the clients served by HRSA programs. For example, major public hospitals are struggling in some cities (Phoenix) and

thriving in others (Cleveland). Those which are struggling may restrict services or be forced to close. Either outcome strongly affects those who use those facilities, especially the uninsured. When the public hospital system has created its own vertically integrated system, as in Cleveland (and Boston, through consolidation), public hospitals are more likely to develop their own ambulatory care system rather than contract with CHCs for primary care, which is what has happened in Cleveland.

D. TECHNOLOGICAL CHANGE

Although we did not directly observe many major technological changes, the people we interviewed alluded to them. For instance, evolving drug therapy is affecting Ryan White programs. These programs were initially intended to provide clinical and support services for clients with a life-threatening condition. More and more, the program is covering the high cost of drug therapy--therapy that improves the quality of and prolongs life.

The development of information systems is another technological change that affects HRSA programs. Most programs are successfully developing and using information systems, but getting the capital they need to use these tools to their full capacity continues to be a challenge. We repeatedly heard that the programs that were most successful at adapting to health systems change were those that were successfully using modem information systems.

Finally, the potential to offer clinical service via telemedicine is a technological change that can have a major effect on HRSA programs. In telemedicine, consultations are conducted from a distance. While telemedicine has until now been used primarily at rural sites, it can be useful in urban areas as well. We did not hear of this technique being used, yet, but it was alluded to as a tool with the potential to increase the breadth of services.

E. MARKET EFFECTS ON INFRASTRUCTURE DEVELOPMENT

Market competition has both positive and negative effects on HRSA grantees' ability to partner, plan for the future, and to tap into additional resources.

1. Collaboration

One example of the effect of market changes on collaboration is found in Cleveland. In that city market changes first led to a collaborative relationship between the Northeast Ohio Neighborhood Health Services (NEON), a network of CHCs, its associated HMO, Total Health Care Plan (THCP), and University Hospital, an academic health center. Between 1987 and 1994, NEON and University Hospital collaborated to address the problem of moving non-emergency patients out of the hospital emergency department and into primary care settings. NEON was responsible for managing an adult urgent care center in the emergency room at University Hospital that received non-emergency cases triaged from the emergency room. The center linked patients without a usual source of care to NEON and other primary care centers. This arrangement also allowed for collaboration in health professions training; for instance, NEON NHSC clinicians provided services at the center and University Hospital staff were responsible for teaching functions in the NEON clinic.

University Hospital derived the following benefits from this collaborative venture: (1) the emergency room became less congested, (2) medical residents received more and better exposure to primary care services training, and (3) hospital emergency costs were reduced because the hospital no longer treated non-emergency cases for the low, fixed rate reimbursed by Medicaid. NEON benefitted as well--it received an important client base of Medicaid patients and opportunities for FQHC reimbursement.

While this collaborative effort was viewed as "successful," changes in the health care market led to its demise. In 1994, University Hospital entered into a relationship with an HMO. creating competitive tensions with NEON's THCP. which was also enrolling Medicaid and commercial clients. By 1995, competition in the Cleveland market had escalated, with 11 HMOs competing for Medicaid managed care clients, Competition for patients eventually contributed to the termination of the collaborative effort and the abrupt loss of 35,000 covered lives from the THCP client census. The significant loss of covered lives caused havoc for NEON staffing, utilization, general performance, and financial viability. It also caused a clinic to close. According to informants, NEON was slow in responding to the loss of clients and was not positioned to respond to the loss of market share or to make administrative and infrastructure changes that would accommodate the smaller client base. Consequently, in this rather extreme example, the intense competition for clients and a reluctance to refer patients from one program to another destroyed the relationship and resulted in NEON's loss of a considerable amount of Medicaid market share and a reduced role in health professions training.

2. Assessment and Planning

Changes in the health care market can also affect assessment and planning for services. For instance, increased competition can make programs reluctant to share information on their clients or services. Also HRSA grantees are sometimes left out of critical planning activities surrounding, for example, health care financing program design.

In Boston, we heard that the State Department of Public Health, which administers many HRSA programs including the PCO, CHCs, and MCH programs, has participated only in a limited way in state policy decisions about health care reform. Policy decisions are made out of the governor's

office with the assistance of two key state health care divisions--the Division of Medical Assistance (DMA) and the Division of Health Care Finance and Policy (DHCFP). The DMA administers the Medicaid program, and the DHCFP administers the Uncompensated Care Pool and develops health care pricing policies, payment methods, and rates. Until recently, the Department of Public Health had not obtained a "place at the table" where financing decisions that have significant implications for primary care programs are made. While still not fully involved in decision making, the department, through the PCO, recently began to assist the DHCFP in implementing its new health care financing program--the Child Health Insurance Program (CHIP). The PCO administers mini-grants to community-based groups for CHIP outreach. These grants are funded through the Uncompensated Care Pool.

3. Resource Development

Changes in the health care market can also affect HRSA grantees' financial resources by increasing competition among providers for market share. For example, in Boston, the growing emphasis on outpatient care and managed care delivery systems has transformed the health care market. In particular, there have been active mergers and acquisitions among health care providers to expand service areas and improve market share. And as more and more people eligible for Medicaid enroll in Medicaid managed care, new market opportunities for providers arise. To remain competitive in the changing marketplace, CHCs have begun to seek alliances among themselves and with other providers. Boston HealthNet, a CHC network, is discussing formal organizational affiliations with other centers and large integrated systems, while Neighborhood Health Plan, a community health center HMO, is actively pursuing a formal affiliation with Harvard Pilgrim Health Care, the largest HMO in the state, and with other commercial plans.

Human resource development can also be affected by market changes. Over the past five years, the four medical schools in Boston have increased their emphasis on the training of primary care physicians in response to increased demand for these providers. As a result, there is a greater need for training and mentoring in CHCs. As training sites, CHCs absorb much of the cost of training activities and effects of these activities on productivity because they value the services of trainees and the opportunity to recruit staff from among them. However, once training is complete, CHCs face strong competition from other providers also hiring new primary care physicians, even through the cost of training has been absorbed by the CHCs and their medical school partners. CHCs are also often at a competitive disadvantage because salary levels are lower than those offered by other providers. In Phoenix, we were also told that this competitive disadvantage comes in part from the high level of administrative burden on CHC providers. That is, compared with other providers, CHC providers must spend more time on administrative paperwork for reimbursement and on meeting federal reporting requirements. Physicians often leave CHCs for other environments such as managed care plans where the administrative burden is perceived to be simpler.

IV. SUGGESTIONS FOR FACILITATING INFRASTRUCTURE DEVELOPMENT THROUGH HRSA PROGRAMS

HRSA has a fiscal responsibility to make the best use of the limited federal funds allocated to its grant programs. To this end, HRSA strives to award new grants to programs that do not duplicate existing programs and to fund high-quality programs and services. It also tries to develop programs that can be sustained by state and local funds, thus freeing up limited federal funds for new and innovative programs that fit current national funding priorities. It uses grant requirements both for the grant proposal as well as award conditions, to foster these goals.

All HRSA programs face the problem that grant requirements may stifle creativity and limit the extent to which state and local administrators can customize their programs to local problems. Some requirements are expensive to implement, since they may, for example, require new data collection. Such requirements may consequently take federal funds away from the services that programs are designed to develop.

While conducting the site visits, the teams examined how programs have met their management and oversight responsibilities, as well as what they appreciated most about HRSA's role and what they found difficult about it. We also asked informants to provide suggestions for HRSA management that could improve HRSA's attempts to foster the development of a health care infrastructure at the community level. These findings are discussed according to the following components of HRSA activities:

- Grant proposal requirements, most notably the requirement for a needs assessment
- Collaboration requirements
- Setting standards and performance measurement

. Technical assistance

A. GRANT PROPOSAL REQUIREMENTS

All HRSA programs require an extensive grant proposal. In the proposal, the candidate grantee describes activities it has planned for the coming year in detail so that grant reviewers (usually central or regional HRSA program staff) can determine whether the proposed use of funds matches program goals and requirements. Over time, this grant process has evolved into a management tool, and HRSA has used the grant proposal to stimulate the planning process at the local level. By doing this, HRSA has hoped to achieve two things: (1) to persuade applicants to involve the wider community in preparing the application and (2) to base its funding decisions on actual data on the need for the proposed program components. These two activities generally form the backbone of the needs assessment process.

We found that this process is often, but not always, successful. The first goal in the process--involving the wider community--is difficult to achieve. Busy people with other job responsibilities are stretched when they have to prepare a long grant proposal, and it is certainly possible (and perhaps easier) to prepare a thorough and impressive grant application without the extensive involvement of individuals outside the applicant organization. As noted, Title V agencies are required to involve individuals outside their own organization in their grant proposal, but in the three cities we visited we found that this involvement was usually rather perfunctory. Only a single meeting might be used to solicit such input, for example. Even when several individuals reported having attended such meetings, they often did not feel that their input was valued or used.

The second component of the needs assessment process, basing an application on actual data, is another excellent way to ensure a fair grant process. HRSA now requires applicants to include

such data in grant proposals for CHC, Healthy Start, Ryan White, and Title V programs. In fact, for CHCs, HRSA is moving in the direction of basing the actual size of a grant on the data (for example, on the number of client encounters). In addition, CHC data systems have evolved (with much effort) to the point where most applicants have accurate and comparable measures on which HRSA can base funding decisions,

Additional sources of data for planning are the HRSA-funded PCOs in each state, which are developed and effective to varying degrees from state to state. Unfortunately, the very high quality data that many PCOs produce are not widely disseminated or used by the HRSA grantees in the cities we visited.

Although the data-based planning process is evolving, it is doing so unevenly. HRSA could facilitate the process in several ways, making it easier for grantees as they prepare their extensive applications and making the data a more reliable and useful for funding decisions. Site visitors offered the following suggestions, based on discussions following site visits:

- Review the data requirements for all HRSA programs, at least the major ones mentioned above. Come up with a template for a core set of needs assessment data (e.g., population of the area, number of primary care providers, etc.). Encourage all HRSA grantees in a state or local area to share these data. (Obviously, each program would have its own specific needs assessment requirements, such as HIV prevalence rates for Ryan White programs, that would not cross program areas.)

- Base the required information on existing data sets to the greatest possible extent. Provide grantees with tools to acquire and analyze data (e.g., CDC Wonder). Provide technical assistance through conferences or workbooks on how to use the tools.

- Consider drawing on PCOs to provide data for needs assessments for HRSA grantees within a particular state. This would give PCOs a more concrete purpose, standardize the data collected across HRSA grantees. and provide a linkage across HRSA programs at the state level.

- Tie the data requested to funding priorities at the national level. This would create a stronger link between requested data and HRSA funding decisions.

- Tie the timing period of required data to the funding year (e.g. fiscal year vs. calendar year).

B. COLLABORATION REQUIREMENTS

As mentioned, HRSA programs are required to collaborate with other agencies and organizations in some fashion. The requirements are more or less formalized and structured. We asked informants what HRSA could do to facilitate this collaboration process.

First, several interviewees requested that HRSA more clearly define the purpose of collaboration. If HRSA could clarify goals when presenting collaboration requirements to grantees, projects would have a benchmark against which to measure the success of collaborative efforts. For example, HRSA might state that funds must be fairly distributed across a range of providers according to set priorities. This seems to be the Ryan White program's primary goal, since much of the planning council's activity centers around deciding how to distribute funds. As one informant put it, "From my point of view, it would be helpful if there were expectations from the feds on how programs should interact."

HRSA might also more explicitly state that programs should be culturally appropriate, accessible, and otherwise sensitive to community needs. For projects, this would mean stepping up efforts to involve consumers in the collaborative process, which is a requirement for CHC, Healthy Start, and Ryan White programs.

Once the goals of collaboration have been clarified, some structural mandates seem to facilitate the process of collaboration. These mandates might take the form of requiring projects to develop certain committees or a certain type of collaborative body with a certain size and composition. Providing technical guidance on fostering collaboration is also very important, perhaps in combination with minimal fixed requirements. It is noteworthy that, while most of the major HRSA

programs do have collaboration requirements, they have evolved separately from one another. Close communication that would allow one program to learn from another's experience does not seem to have taken place. For example, CHC community boards have been in existence for many years; yet requirements for a similar body in the Ryan White and Healthy Start programs evolved independently from consideration of the CHC requirements.

Almost across the board, informants suggested that collaboration could be fostered by bringing programs together at the federal level before the local programs are asked to collaborate. For instance, informants frequently cited the requirement that HRSA programs collaborate with Medicaid. As one respondent said, "We're told to collaborate with them, but they are not told to collaborate with us." Respondents pointed out that local HRSA programs do not always relate well to one another at times because of their conflicting agendas. Problems like this could be mitigated if federal players presented a common front and demonstrated mutually supportive relationships (for example, appearing jointly at national meetings and sponsoring joint grant solicitations).

As another example, according to informants, the historical division that has long caused tension between the Bureau of Primary Care and the Bureau of Health Professions has filtered down to the state level and has negatively affected collaboration at the local level among the NHSC, CHCs, PCOs, PCAs, and the AHEC programs. At some sites, CHCs appeared to function as "free agents," completely separate from the PCA and the PCO. Links between CHCs and health professions training programs are also weak in some sites.

One of the most telling examples of the need for collaboration among HRSA programs comes from the MCH cluster, where the objective as well as the populations of the three programs in this cluster--CHCs, Healthy Start, and Title V--overlap considerably. The overlap and the resulting need

for collaboration at the federal level is not as marked with the AHEC/Health Professions and Ryan White programs.

Some informants suggested that if HRSA wants more collaboration among its grantees, requirements must be accompanied by financial incentives, such as designated funding for collaborative activities and funding to attend national conferences . In summary, simply requiring programs to collaborate is not enough. HRSA should also take steps to ensure that this collaboration is meaningful, attainable, and seen by programs as something that is rewarded. If this does not happen, the result is likely to be fairly superficial collaborative activities associated with continuation of the status quo, which, in turn, could result in each program pursuing its own isolated agenda.

C. SETTING STANDARDS AND MEASURING PERFORMANCE

One HRSA goal is to direct funds to high-quality, efficient programs. While there is also a desire to foster local control and innovation, the movement toward setting some standard level of performance is underway for several of the programs we examined, most notably CHCs and Ryan White programs. Local staff must balance their desire to customize programs for their community with meeting federal performance standards. We heard conflicting opinions about these performance measurement efforts, but, because they are very recent, it is too early to determine with confidence how well the measurement process is working.

In more than one instance, we heard that there is a great deal of anxiety among programs about how performance measurement would ultimately affect their funding. For example, programs that provide population-based services such as outreach are nervous about being judged according to the number of clients that they serve--a figure that cannot be easily tabulated. On the whole, however,

most reactions were positive. First, the push toward performance measurement has improved the local programs' ability to collect data, and the data they report to HRSA can be used for other management purposes. Several CHCs brought out their reports from the Uniform Data System and were proud at last to be able to provide concrete information on the number and characteristics of their clients.

Also, most programs feel that it is legitimate and appropriate for HRSA to take on an oversight and monitoring role. Indeed, many were proud of their program and looked forward to the opportunity to showcase it and be rewarded for their efforts. However, they emphasized that it is very important for HRSA to lay out its expectations well in advance and to take a quality-improvement, rather than a punitive, approach to problems.

For some programs (e.g., Healthy Start), grant officers are stationed at the central office. For others such as CHCs, they are stationed at regional offices. Discussions with federal regional office staff revealed concerns about their capability to monitor performance. Recent cutbacks in the staff at regional offices of the Department of Health and Human Services raises concerns about whether intensive (or even moderate) oversight of grantee performance is possible. Similar concerns could presumably arise if, for example, the grant officer staff does not grow as the number of Healthy Start grantees grows. A performance monitoring process that is feasible on paper but not in practice is likely to be viewed with cynicism, and if grantees feel this way about the process they will not be inclined to try to meet performance standards.

Another potential barrier to making standards and performance measurement work is that grantees' data collection capabilities are limited. Some grantees reported that the data requirements for performance measurement are unrealistic. For instance, most HRSA programs, do not have standard person level data collection. Many grantees asked HRSA to provide, more technical

assistance in the area of data development, including, perhaps, helping to develop standard software packages that would be provided free. To the extent that reporting requirements could be standardized across HRSA programs, this would represent a potential cost savings to grantees. One CHC reported that it had to purchase one software package for Ryan White reporting and another for CHC reporting.

D. PROGRAM TECHNICAL ASSISTANCE

It is difficult and expensive to provide effective technical assistance to such diverse grantees and local programs, yet many reported needing such assistance from HRSA and appreciating it when it was given. An example of a very helpful process is the "MCH pyramid," which the MCH Bureau has advocated as a conceptual approach to refocusing the Title V program. State programs have used the "pyramid" extensively in deciding how to plan for the allocation of state Title V funds.

The PCAs, which are often funded to provide such assistance, caution that CHCs (and presumably other programs) may not know when they need assistance and so may not be receptive to it. Assistance in the following areas might be viewed favorably:

- Approaches to collaboration
- Goal setting, performance measurement, data systems, and evaluation
- Approaches to costing services, both for reimbursing providers and for billing managed care plans
- Grant writing and obtaining nonfederal funding

Grantees offered the following suggestions about how to improve the technical assistance process:

- Provide more user-friendly written materials
- Rely on innovative technology such as chat rooms and dial-in teleconferencing. Chat rooms can be especially helpful in times of change--for example, when rate-setting approaches are revised.

V. HRSA STAFF FEEDBACK

In this chapter, we discuss HRSA staffs' impressions of the methodology as a learning tool for HRSA management.

A. THE PILOT STUDY AS A LEARNING TOOL FOR HRSA MANAGEMENT

As a learning tool for HRSA management, the pilot study has been useful in three main ways. First, the site visits allow HRSA representatives to view directly the health care infrastructure associated with HRSA programs and to examine the interaction of HRSA programs. The visits also allow grantees to explain the value that HRSA funds add to their program operation. Through this process, the visits expose HRSA team members to programs other than their own and to the communities their programs serve. The visits also generate many ideas for improving HRSA programs. Finally, the visits have stimulated new hypotheses that could guide future evaluations.

1. Opportunity to View Infrastructure Building at the Community Level

The value of the site visits lies in the opportunity they afford HRSA representatives to observe programs and to learn firsthand how they contribute to infrastructure building. HRSA representatives, acknowledge their own challenge of having to explain "infrastructure building" to those outside HRSA and, in some cases, to those in the agency, including the administration. Having observed infrastructure activities directly, HRSA representatives now feel that they are better equipped to explain them and thus to explain the importance of HRSA funds in fostering such activities in communities. In addition, representatives believe that they now have more insight into different models of infrastructure building and into grantees' needs for technical assistance.

Most HRSA representatives told us that, in addition to providing them models of infrastructure building, the site visits also provided invaluable opportunities to observe programs at the community level. They got a firsthand view both of the challenges and frustrations faced by program managers, particularly for HRSA programs with which they are less familiar. One HRSA representative commented that the site visits increased her awareness of just how pressing public health needs are in these communities. For another representative, the visits brought to light the distance between people of different races and political affiliations, and how these differences challenge the collaborative process. Moreover, the site visits have reminded HRSA representatives that federal, state, and local politics play a key role in the relationships among programs. Site visitors learned more about organizational tensions between some HRSA programs and the perception that these tensions were, in part, offshoots of poor program relationships at the federal level.

2. Ideas for Improving HRSA Programs and Program Requirements

Informants enthusiastically offered suggestions for improving HRSA programs, many of which the HRSA representatives found worthy of management consideration. Particularly attractive suggestions included clarifying program expectations around collaboration, improving the readability of the program application and other documents, providing more technical assistance around performance measurement and the costing out of services, and providing better opportunities for sharing information among program grantees.

The site visit experience also emphasized for HRSA representatives the need to improve collaboration among HRSA programs. To address this problem, some HRSA representatives suggest holding a regional meeting for all HRSA-funded program representatives. This would not only give program representatives an opportunity to provide HRSA with feedback regarding

program challenges and other issues but would also create an avenue through which HRSA-funded programs could collaborate.

HRSA representatives note that some regional meetings could focus on improving collaboration with other Health and Human Services programs that interface with HRSA programs. The representatives point out that informants at all three sites highlighted the difficulties involved in interfacing with Substance Abuse and Mental Health Services Administration-supported programs. Many of these programs receive Ryan White funds but are not well-integrated into Ryan White planning councils or consortia. Involving these programs in regional meetings could contribute to a more seamless system of care in the community.

The site visits added to the HRSA representatives' understanding of how grantees feel about program requirements. For example, program requirements and guidance related to community participation has made a big difference, from program to program, on the structures for collaboration. Ryan White consortia appear much more sophisticated in terms of structure and decision making than did the Healthy Start consortia. HRSA representatives were pleased to learn that Title V and Healthy Start program informants welcomed the notion of accountability as a means to improve their programs. Ryan White informants felt otherwise. They expressed strong negative feelings about the utility of the standard annual administrative report and the burden it imposes on the program.

3. Opportunities for Hypothesis Development and Ideas for Future Evaluations

The methodology in this pilot study is not intended to be used for formally evaluating HRSA programs. However, it has proven extremely useful for stimulating ideas and hypotheses to be tested in more formal evaluations and as a method to assess performance measures related to infrastructure

building. In this section, we give examples of research topics, suggested by the pilot methodology, that might be explored in the future.

During site visit debriefing, it became clear that the research teams were developing research questions as they continuously reflected on issues raised throughout the day. For example, the striking differences in the operation of Healthy Start consortia and Ryan White planning councils raised questions about the extent of guidance or direction that grantees should be given on how to form and operate these bodies. An evaluation of the different models used to obtain community input and of their effectiveness in carrying out the program goals could result in a "best practices guide" for involving community partners.

The research team also noticed that HRSA programs struggle to balance the medical, behavioral, and social needs of clients. CHCs focus first on the medical needs of their clients and second on providing services that support medical care. In contrast, Ryan White Title I program priorities appear to depend on the availability of medical services in the community. For example, in states that generously support HIV medical care, the priority of Ryan White Title I is to provide supportive social and behavioral care. An evaluation that more clearly delineates the relationship between resources available for medical care and program priorities would help to inform HRSA about how to refocus programs to meet community needs, in a way that is tailored to the needs of individual communities.

Another issue worthy of evaluation is the degree to which the effectiveness of a HRSA program is related to its location in an organization. For example, we observed that co-locating several programs in the same department unit allowed a higher degree of collaboration among these programs and facilitated the leveraging of additional funds. We also heard that programs have limited input into policy making around improved access to care if decisions about these policies

occur in other divisions. Studies that attempt to elucidate the influence of location and organizational structure on program effectiveness could help HRSA "place" programs in a way that maximizes their possibility for success.

The site visit experience also prompted HRSA representatives to think more concretely about how the pilot study could help their management think about infrastructure-building activities from the perspective of performance measurement. In particular, there is a need to more clearly define levels of and criteria for "better performance" in contrast to "poorer performance." There is also a need to develop a systematic approach to identifying missed opportunities for infrastructure building and for assessing their effect on communities.

B. STUDY DESIGN

Another primary objective of this pilot study is to identify the methodological lessons from the study. The two primary design features of this methodology which were important to test are: (1) the composition of the site visit research teams, which HRSA and MPR staffed, and (2) the semi-structured interview protocols used for data collection.

The site visits used joint HRSA/MPR site visits teams. In general, HRSA representatives feel that the MPR/HRSA team approach to the site visits works very well. HRSA representatives appreciate being included and find great value in the opportunity to get a sense firsthand of their programs in action. HRSA representatives also learned from participating in the interviews of programs with which they do not regularly work. For example, HRSA MCH staff were able to observe the results of federal guidance for Ryan White and Healthy Start in terms of collaboration, assessment, and planning.

HRSA representatives also feel the site visit protocols are a useful guide for the interviews in that they were able, in most cases, to solicit valuable information from informants. They also noted that formulating difficult questions (i.e., "have there been any additional spin-off effects of your program?") became easier as they gained experience with such questions and observed respondents' reactions. This experience could be used to improve future protocols, probably by shortening them and leaving more open-ended questions.

Some HRSA representatives commented that the Ryan White, Title V, Healthy Start, and MCH programs are particularly good for studying approaches to collaboration, and that health professions programs are less well suited for addressing this particular study issue. This does not relate to the quality of such programs, but rather to the fact that there are fewer collaboration requirements for health professions programs.

While HRSA representatives reacted positively to their site visit experience, they made two important comments regarding site-visit preparation and informant interviews. First, they said that a meeting between MPR and HRSA representatives prior to the actual site visit would be very helpful. Such a meeting would allow them to exchange impressions with MPR staff after reviewing background materials on the site and to highlight specific issues to focus on during interviews. Second, HRSA representatives mentioned that they would have liked to have backup strategies for meeting with program directors who are unavailable during the site visit. Such strategies could include budgeting for a designated number of telephone interviews with programs directors at a later date.

VI. CONCLUSIONS

This pilot study of three communities where a variety of HRSA programs currently operate was conducted for the following two purposes:

- To identify how HRSA programs facilitate infrastructure building at the community level
- To identify lessons from the pilot study methodology

This chapter discusses the implications of what we observed about infrastructure activities in the following areas:

- Developing and sustaining strong collaborative relationships
- Conducting assessment and planning activities
- Developing fiscal and human resources

It also points at additional measures of infrastructure building that could be used in subsequent studies of these issues.

A. DEVELOPING AND SUSTAINING STRONG COLLABORATIVE RELATIONSHIPS

In contrast to rural communities, cities like the ones we visited have complex health care markets. These markets represent the confluence of managed care organizations, hospitals, academic medical centers, public health care delivery systems, and community-based systems of care. On the one hand, this complex array of systems gives HRSA programs numerous opportunities for collaborating to make effective health care accessible to people in traditionally underserved communities. On the other hand, a complex urban health care market poses significant challenges

to collaboration. The programs we visited struggle to develop and sustain collaborative relationships within their own programs and with other HRSA programs. Many of these difficulties are related to defining collaboration and understanding how to implement it. A variety of forces appear to influence collaboration: historical relationships between entities, trust, and issues related to race and the political environment.

A history of collaboration or cooperation in the community makes it easier to form partnerships. In such an environment, individuals and programs are more likely to work together, trust each other, and collaborate. In some cases, trust issues take the form of "turf' issues, which are clearly a problem for programs such as Ryan White and Healthy Start. Providers involved in these programs fear losing leadership roles or funding opportunities to other providers. In other cases, trust issues are related to race, primarily egregious behaviors associated with past federal programs such as the Tuskegee Syphilis Study. This negative experience has bred fear among some minority groups, making them reluctant to collaborate with federal programs.

Federal, state, and local politics also influence the willingness of local HRSA programs to collaborate. Historical divisions between programs at the federal level appear to have created tension between some local HRSA programs. As several informants pointed out, collaboration at the federal level would help to in encourage collaboration at the state and local level.

Programs are also affected by changing state politics that mirror national trends like the move toward competitive bidding for services. For some programs, this change has eroded trust and collaboration among providers because they now find themselves vying for limited program resources. But competition has also had a positive effect on service delivery. As programs position themselves to maintain market share and funding, they have consolidated, redefining their mission and broadening their scope of services to reach previously underserved populations.

Possible indicators of a program's ability to develop and sustain effective collaborative relationships include measures that assess the extent to which:

- The goals of collaboration are clear, and they are understood by partners.
- Partners feel that their input is valued.
- Partners believe that the benefits of collaboration will offset losses in autonomy and turf
- Strategies such as leadership training and retreats for partners are in place to ensure that effective formal and informal communication occurs among partners.
- Clear mission has been set, and strategies are in place, to engage racial and ethnic minorities and grassroots representatives in the collaborative process.
- Strategies are in place to minimize the negative effects of competition among providers.

B. CONDUCTING ASSESSMENT AND PLANNING ACTIVITIES

For many HRSA programs, the grant application process has stimulated formal assessment and planning at the local level. While for some programs this process is somewhat perfunctory, for others it serves as an important tool for setting priorities and guiding the fair disbursement of program funds.

Assessment and planning activities have had a significant impact on HRSA programs' ability to identify opportunities for improving services. We observed numerous examples of better-coordinated and better-integrated services that have developed as programs assess the service delivery landscape, identify opportunities for sharing fiscal and human resources, and streamline services. We also identified missed opportunities for improving services. The lack of coordination between CHCs, PCOs, and MCH programs is an example of this situation. These programs serve the same populations but conduct the majority of their assessment and planning activities independently. They also rarely share program data.

Possible indicators of a program's ability to effectively evaluate and plan program activities include the following:

- Systematic community participation is included in formal assessment and planning.
- Information developed as part of the assessment and planning process is broadly shared with other HRSA programs affecting similar populations.
- Assessment and planning are conducted jointly with other HRSA programs.
- Assessment and planning identify opportunities to improve service delivery (e.g., coordinate or better integrate services).
- Identified opportunities for service delivery improvement are acted upon.

C. DEVELOPING FINANCIAL AND HUMAN RESOURCES

Densely populated communities with clusters of low-income and minority racial and ethnic groups must continually secure financial and human resources to promote access to health care for vulnerable populations. In the communities we visited, HRSA funds played an extremely important role in filling gaps in the health care safety-net. According to our informants, some services would not exist or would be significantly reduced without HRSA funding. Programs use HRSA funds as the means for leveraging additional funds. We were told repeatedly that HRSA funds, regardless of the amount, were -used to leverage additional funds in order to expand or build upon existing programs.

Like financial resources, the right human resources are also key to improving access for vulnerable populations. A critical barrier to access in underserved communities is the lack of physicians who are trained to address patients' health care needs. The family medicine programs and the NHSC, for example, expose health professionals to safety-net providers, helping them learn how to tailor care to the special needs of vulnerable populations. Moreover, training programs also

provide an opportunity for health care providers to identify students as potential employees who can bring new knowledge and up-to-date guidelines to the community.

Possible indicators of a program's ability to effectively develop fiscal and human resources include measures that assess the extent to which:

- Programs share funds with each other to meet similar objectives, developing seamless systems of care that address unmet needs.
- Program use HRSA funds to secure additional funds to sustain or expand their activities without losing their primary mission or focus.
- Programs share human resources, such as health personnel, using people from one program to provide services for another.
- Health professions training programs create opportunities to integrate students into the service delivery activities of HRSA nontraining programs, such as Ryan White, MCH, CHC, and AETC programs).
- Programs hire health professionals who have been trained in HRSA-supported programs.

D. LESSONS FROM THE PILOT STUDY

As a learning tool for HRSA management, the pilot study has been useful in several ways. First, HRSA representatives were able to obtain firsthand knowledge of concrete infrastructure building activities and to observe a variety of HRSA programs within the context of the communities they serve. Second, numerous ideas for improving HRSA programs were generated by informants and HRSA representatives. In many cases, these ideas represent areas programs report needing technical assistance (e.g., assistance in approaching collaboration, goal setting, and performance measurement; assistance in developing data systems; and assistance in the rate setting and billing process) from HRSA. Other ideas take the form of specific suggestions for how to improve the ways in which HRSA programs conduct their activities (e.g., facilitate information sharing among grantees through

the use of computer technology, teleconferencing, and HRSA- sponsored regional meetings; provide more user-friendly written materials; and improve collaboration among HRSA programs at the federal level), Site visits were also valuable in that they stimulated the identification of possible indicators to assist HRSA in defining program performance measures in the area of infrastructure building, as outlined above. Finally, the exploratory nature of this pilot study encouraged brainstorming, developing ideas, and new hypotheses that could be tested in more formal evaluations of HRSA programs.

The following components will contribute to the success of future site visits:

- Interview key people in the local health care system, both HRSA grantees and others, to obtain a balanced perspective on the impact of HRSA's presence in the community
- Invest time in gathering information from HRSA grant managers and the regional offices as well as identifying existing projects that describe the community
- Organize this information so that it becomes the basis for probing interview subjects
- Emphasize to potential respondents that the project is not a program evaluation.

In summary, the pilot study was a successful first step toward a more concrete understanding and description of the health care infrastructure and its development in the context of HRSA programs. We hope that the observations presented in this report will assist HRSA managers in their continuing effort to assess how HRSA programs improve access to care in underserved communities.

APPENDIX A

CROSS-CUTTING COMMUNITY CASE STUDY PROTOCOL

I. INTRODUCTION

This protocol is to be used for site visits for the Cross-Cutting Community Study during February and March 1998. Three cities will be visited: Cleveland, Phoenix, and Boston. All of the cities are also part of the Community Tracking Study of the Center for Studying Health System Change.

The purpose of the study is to evaluate the interactions among specific HRSA funded programs and the collective influence of their sponsorship on the communities in which they exist. The study seeks to examine the infrastructure of various HRSA programs and to see how relationships within and among different HRSA programs accomplish certain goals. The intent is to better understand the capacity building ability of HRSA programs so that it can be measured and the need for such programs can be determined. The three major research questions of the study are:

- To what extent do HRSA programs facilitate cooperation and partnering among agencies to better target public health needs in the community?
- What are the implications of changing health care market forces for HRSA grantees and for their linkages to other providers and agencies in the communities?
- What is the collective influence of HRSA programs on communities?

The protocol will include an introduction in which the interviewers will provide an explanation of the purpose of their visit. The introduction will also provide interviewees with an opportunity to explain the organizational structure of their program, and define their position and their specific responsibilities within the program. The protocol includes questions that are categorized according to five topic areas. The areas are as follows:

- Funding streams
- Planning process
- Linkages with other programs
- Response to market changes
- HRSA relationships

To conclude the interview, interviewers will ask informants to discuss their vision for their respective program over the next 3 to 5 years.

We have spoken with individuals within HRSA in order to identify the appropriate federal level contacts for each program. We will speak with federal program contacts to identify grantee contacts for each program in each site. These contacts will be interviewed, using the following protocol. Most interviews will be in person, but some will take place over the telephone. We are also in the process of obtaining annual grant applications for Title V, Ryan White, Community Health Centers and Healthy Start programs in each of the communities. These will be reviewed prior to the site visits so that we do not ask questions which are answered in the application.

II. RYAN WHITE PROTOCOL

A. INDIVIDUALS TO BE INTERVIEWED

Table 1 shows the individuals to be interviewed for the Ryan White Programs in each city. Also shown is the way in which we will identify each person. and the names of those we have identified so far.

TABLE 1

RYAN WHITE INTERVIEWEES BY SITE

	CLEVELAND
Ryan White Title I Director	Sandra Chappelle
Ryan White Title 1 Provider	MetroHealth, Infectious Disease Clinic Dr. Robert Kalajyian
Ryan White II Director	Sally Boals
Ryan White II Provider	AIDS Task Force of Greater Cleveland (Chrisse Franz)
Pediatric AIDS Provider	None
Planning Council Representative	None
	PHOENIX
Ryan White Title I Director	David Paquette
Ryan White Title 1 Provider	AIDS Project Arizona (Peter Houle, Executive Director)
Ryan White II Director	Judy Norton
Ryan White II Provider	Northern Consortia-Coconino County Health Department (Betty Brown, fiscal advisor--Flagstaff)
Pediatric AIDS Provider	Bill Holt Infectious Disease Clinic (Judy O'Haver)
Planning Council Representative	Northern Consortia-Coconino County Health Department (Betty Brown, fiscal advisor--Flagstaff)

TABLE 1 (*continued*)

	BOSTON
RWTitle I Provider	East Boston Neighborhood Health Center: (John Craddock-Executive Director) Dimock Community Health Center (Jackie Jenkins-Scott)
RW Title II Director	John Auerbach/David Ayotte
RW Title II Providers	North Shore AIDS Collaborative (Diane Kuzia) Lynn CHC (Cathy Lique)
Pediatric AIDS Provider	Dimock Community Health Center: Jackie Jenkins-Scott See Above
Planning Council Representative Consortium Representative	Althea Alelia Munroe (at Dimock Community Health Center)

B. INTERVIEW GUIDES

B.l FEDERAL CONTACTS: PROJECT OFFICERS FOR RYAN WHITE TITLES I AND II

1. One of the ways that HRSA programs begin collaborations is through the grant application process. Can you give me an overview of the application process for Ryan White funds? Are there explicit, or implicit partnerships that the federal government is trying to foster, for example, with types of provider institutions, non-health social service agencies, community-based providers? Please tell us what is explicitly required and what guidance you are given. In sum, what are the expectations and how are they conveyed?

2. Are there any specific circumstances, or situations unique to the site that we should be aware of prior to our site visit?

3. Can you give us a sense of how the program is functioning; any problems, challenges, or successes particularly related to linkages to other HRSA programs, or other non-HRSA health providers or agencies?

4. Are there any critical partners or key players beyond the Title I Director that we should contact?

5. Have managed care and other market changes, such as mergers, begun to impact the delivery of Ryan White services? In what way? How have changes in the market environment impacted the delivery of care provided through Ryan White funding? Have these changes affected program partnerships or collaborations?

B.2 TITLE I AND TITLE II DIRECTORS

(Questions are to be asked of both Title I and Title II Directors unless otherwise specified.)

Grant Application Process

1. (For TITLE I) One of the ways that HRSA programs begin collaboration is through the grant application process. In the Title I grant application there is a large emphasis put on the creation and operation of the Planning Council, which involves the participation of many different community members and groups. Can you tell me about the planning process for the Ryan White Title I Grant Application? Did the process of obtaining Ryan White funding cultivate any new partnerships or community coalitions?

2. (For TITLE II) According to the Title II grant application, you are required to provide information regarding certain partnerships you maintain with other organizations which deliver care with Title II funds for the Annual Administrative Report, or for the development of the Statewide Coordinated Statement of Need. Who were your partners for the Title II Grant Program Application? (Omit if information is provided in the grant application.)

3. How was information collected during the application process? Was this information shared with other community partners? For example, is data collected regarding community HIV/AIDS incidence and, risk factors used for purposes beyond Ryan White, such as other community health program planning? Who was involved in providing information necessary for the completion of the application? During the application process, did you feel that you had the capacity (for example, adequate staff) to complete the application? In your view, why are some cities more capable than others to fulfill application requirements? Did you find the application process to be a useful exercise? (Explain that we are trying to understand the extent of importance of the grant development process resulting in something meaningful.)

4. Do you think the partnerships that are required by the Ryan White Grant Application would have been created if they were not required? What do such linkages accomplish for your program? Do such partnerships help you in your ongoing work? How?

Ongoing Collaborations

5. The next several questions refer to specific collaborations and partnerships that grew out of program activities subsequent to the grant proposal process. How do such collaborations come about? What do you feel programs and organizations need in order to cultivate healthy partnerships (e.g. adequate staff to pursue linkages or sit on committees, requirements from funders to collaborate, etc.)?

6. Does your Ryan White program interact with other HRSA funded programs in the community? In what ways do they interact? What facilitates or prevents interaction among HRSA funded programs? Are there benefits to the co-existence of multiple HRSA programs in a community?

7. Do you participate in any task forces associated with empowerment zones, Healthy Start or others? Are these collaborations important to your program? Has the Community Planning Group given rise to other community planning or service groups? Can you describe your strongest collaboration, in terms of the frequency of participation and the help it gives you in running your program?

8. Are there additional partnerships that would be beneficial to the program, but do not exist? Why do you think these linkages do not exist? Did Ryan White requirements play a role in hindering these linkages?

9. Have there been any other additional spin off effects of your planning council (Title I)/consortium (Title II) activities (such as leadership development, policy development, quality improvement, expanded services, new collaborations, infrastructure development, training and continuing education)?

Market Changes

10. Have managed care and other market changes, such as mergers, begun to impact the delivery of Ryan White services? In what way? How have changes in the market environment impacted the delivery of care provided through Ryan White funding? Have these changes affected program partnerships or collaborations in either a positive or a negative way?

11. Changes in the size of the "safety net" have resulted in a question of which organizations, agencies and/or programs comprise the safety net now and how shrinking in some parts of the net is putting more pressure on other traditional safety net services. How do you see these changes affecting the way in which Ryan White program activities are conducted?

12. Do you envision the need to develop new partners to help you implement these changes?

13. Did the Ryan White grant affect spending priorities in the community? HRSA programs often make certain aspects of a program a priority. Do you feel this, in turn, impacts the way the community sets its own agenda with regard to program activities and funding allocation?

HRSA's Role

14. HRSA sponsors many community-based programs. Looking at your program, do you feel there are HRSA requirements that contribute to the delivery of program services, or ones that create barriers for more effective collaboration?

15. Are there explicit, or implicit partnerships that the federal government is trying to foster, for example with types of provider institutions, non-health social service agencies, community-based providers? Please tell us what is explicitly required and what guidance you are given. In sum, what are the expectations and how are they conveyed?

16. Are the performance measures and reporting requirements helpful? Beyond Ryan White, do you have performance requirements from other funders? What are they?

Wrap-up

17. Can you give us a sense of how the Ryan White program is functioning here; any problems, challenges or successes? How do you see your program changing, if at all, over the next 3 to 5 years?

B.3 RYAN WHITE PROVIDERS

(To be asked of both Title I, Title II, and Pediatric AIDS Providers)

1. Can you briefly describe the activities of your program?

2. What proportion of your program activities are supported by Ryan White funds? What services do you provide with Ryan White funding?

3. What are your other funding sources? In what ways has Ryan White funding helped attract other funds or provided core support that enables you to provide specific services?

4. Were you involved in the Ryan White grant application and planning process? What role did you play? What was the planning process for the application? Did the process lead to new collaborations among groups that were not previously linked?

5. The next question refers to specific collaborations and partnerships that grew out of Ryan White Grant requirements and program activities. First, can you talk a little bit about the purpose behind the linkages that exist to enhance the Ryan White program? Do you collaborate with Health Department at the state or local level? How do collaborations come about and what do you feel programs and organizations need in order to cultivate healthy partnerships? Do you apply for other HRSA grants? Do your linkages with other HRSA programs/grants, with government agencies, and with provider institutions have different purposes? What are they? Are the requirements for different HRSA grants complimentary or contradictory to one another?

6. Have you developed new partnerships as a result of your participation in the Ryan White program? Would these exist without Ryan White funds? What do these linkages accomplish? Do you have a sense for why partnerships exist at all?

7. In addition to the services you provide with Ryan White funds, have there been any other additional spin off effects (such as leadership development, policy development, quality improvement, expanded services, new collaborations, and infrastructure development, training and continuing education)?

8. Have managed care and other market changes, such as mergers, begun to impact the delivery of Ryan White services? In what way? How have changes in the market environment impacted the delivery of care provided through Ryan White funding? Have these changes affected program partnerships or collaborations?

9. Before we end, I would like to ask about health personnel training and resource issues. HRSA supports a variety of training activities in the (Cleveland) area.

   Interviewer: (FYI--HRSA funds support the training of nurses, nurse practitioners, nurse midwives, family medicine physicians (student and faculty), pediatric fellowships, disadvantaged health professions students, health administration traineeships, health career

opportunity programs at the following schools: Case Western School of Med, Bolton School of Nursing, Cleveland State University Nursing, Cuyahoga Community College Metro Campus, and the Ohio College of Podiatric Medicine.

Has your program benefitted in any way from these programs--for example--has it been easier to attract providers (primary care providers, nurses, etc.) to your (Center) because these programs exist in the area?

Does your center have formal linkages or collaborate with these programs in any way?--for example--Does your center serve as a training site for undergraduate and graduate students or provide mentors for students, participate in "grand rounds" on HIV at Case Western or Bolton?

Do providers at your center have greater access to continuing education and other training programs because these programs exist in the area?

Has your center developed or entered into other relationships or participated in other activities because of your involvement with these programs?--for example--participation in a community task force on HIV lead by Case Western, participation in a local school based HIV education program that arose from linkages created through the health careers opportunity program at the school?

III. HEALTHY START PROTOCOL

A. INDIVIDUALS TO BE INTERVIEWED

CLEVELAND	
HS Director	Juan Molina Crespo
HS Provider	Phyllis Burton-Scott at Northeast Ohio Neighborhood Health Centers (this is the renamed Cleveland Neighborhood Health Services/Hough-Norwood
BOSTON	
HS Director	Diane Christmas
HS Provider	

B. INTERVIEW GUIDES

B.l FEDERAL CONTACTS

None Planned for Healthy Start

B.2 LOCAL CONTACTS

HEALTHY START PROJECT DIRECTORS

INTERVIEW GUIDES

Grant Application Process

1. One of the ways that HRSA programs begin collaborations is through the grant application process. Can you give me an overview of the application process for Healthy Start funds? Are there explicit, or implicit partnerships that the federal government is trying to foster, for example with types of provider institutions, non-health social service agencies, community-based providers? Please tell us what is explicitly required and what guidance you are given. In sum, what are the expectations and how are they conveyed?

2. In the application there is a large emphasis put on the creation and operation of the Healthy Start Consortium, which involves the participation of many different community members and groups. Did the process of creating the Consortium, to fulfill the HRSA requirement, cultivate any new partnerships or community coalitions?

3. How was information collected during the application process? Was this information shared with other community partners? For example, is data collected regarding community infant mortality and risk factors used for purposes beyond Healthy Start, such as other community health program planning?

4. Who was involved in providing information necessary for the completion of the application? During the application process, did you feel that you had the capacity (for example, adequate staff) to complete the application? In your view, why are some cities more capable than others to fulfill application requirements? Did you find the application process to be a useful exercise? (Explain that we are trying to understand the extent of importance of the grant development process resulting in something meaningful.)

5. Beyond Healthy Start, do you have performance requirements from other funders? What are they? How do performance requirements contribute to the delivery of program services?

Ongoing Collaborations

6. The next question refers to specific collaborations and partnerships that grew out of Healthy Start requirements and program activities. First, can you talk a little bit about the purpose behind the linkages that exist to enhance the Healthy Start program? How do collaborations evolve and what do you feel programs and organizations need in order to cultivate healthy partnerships? Do you apply for other HRSA grants? Do your linkages with other HRSA funded programs, with government agencies, and with provider institutions have different purposes? What are they? Are the requirements for different HRSA grants complimentary or contradictory to one another?

7. The grant specifies areas in which collaborations should exist--are there other ways in which your participation in Healthy Start has allowed you to collaborate with other local governmental organizations, and other local agencies? Do these collaborations continue to exist? For example, has the Consortium given rise to other community planning or service groups? Can you describe your strongest collaboration?

8. Have you developed new partnerships as a result of your participation in the Healthy Start program? What do you think these linkages accomplish?

9. Are there additional partnerships that would be beneficial to the program, but do not exist? Why do you think these linkages do not exist?

10. Are there explicit, or. implicit partnerships that the federal government is trying to foster, for example with types of provider institutions, non-health social service agencies, community-based providers? Please tell us what is explicitly required and what guidance you are given. In sum, what are the expectations and how are they conveyed?

11. Does the Healthy Start program interact with other HRSA funded programs in the community? In what ways do they interact ? What facilitates or prevents interaction among HRSA funded programs? What are there benefits to the co-existence of multiple HRSA programs in a community?

12. In addition to the services you provide with Healthy Start funds, have there been any other additional spin off effects (such as leadership development, policy development, quality improvement, expanded services, new collaborations, infrastructure development, and training and education)?

Market Changes

13. Have managed care and other market changes, such as mergers, begun to impact the delivery of Healthy Start services? In what way? How have changes in the market environment impacted the delivery of care provided through Healthy Start funding? Have these changes affected program partnerships or collaborations?

14. Changes in the size of the "safety net" have resulted in a question of which organizations, agencies and/or programs comprise the safety net now and how shrinking in 'some parts of the net is putting more pressure on other traditional safety net services. How do you see these changes affecting the way in which Healthy Start program activities are conducted?

15. Do you envision the need to develop new partners to help you implement these changes?

16. Did the Healthy Start grant affect spending priorities in the community? HRSA programs often make certain aspects of a program a priority. Do you feel this, in turn, impacts the way the community sets its own agenda with regard to program activities and funding allocation?

Wrap-up

17. We would like you to give us a sense of what to look at to detect how the Healthy Start program is functioning in terms of linkages with other health and social service organizations and in

developing an infrastructure for service delivery? How do you see your program changing, if at all over the next 3 to 5 years?

B.3 HEALTHY START PROVIDER QUESTIONS (Subcontractors)

1. Can you briefly describe the activities of your program?

2. What proportion of your program activities are supported by Healthy Start funds? What services do you provide with Healthy Start funding?

3. Were you involved in the Healthy Start grant application and planning process? What role did you play? What was the planning process for the application? Did the process lead to new collaborations among groups that were not previously linked? Do you collaborate or coordinate with the Health Department at the state or local level?

4. Can you talk a little bit about the purpose behind the linkages that exist to enhance the Healthy Start program? How do collaborations evolve and what do you feel programs and organizations need in order to cultivate healthy partnerships? Do you apply for other HRSA grants. Do your linkages with other HRSA funded programs, with government agencies, and with provider institutions have different purposes? What are they? Are the requirements for different HRSA funded programs complimentary or contradictory to one another?

5. Do you think the partnerships that are required by Healthy Start would have been created if they were not required? What do you think these linkages accomplish?

6. In addition to the services you provide with Healthy Start funds, have there been any additional spin off effects of the program (such as leadership development, policy development, quality improvement, expanded services, new collaborations, infrastructure development, and training and education)?

7. Have managed care and other market changes, such as mergers, begun to impact the delivery of Healthy Start services? In what way? How have changes in the market environment impacted the delivery of care provided through Healthy Start funding? Have these changes affected program partnerships or collaborations?

8. Before we end, I would like to ask about health personnel training and resource issues. HRSA supports a variety of training activities in the (Cleveland) area.

Interviewer: (FYI--HRSA funds support the training of nurses, nurse practitioners, nurse midwives, family medicine physicians (student and faculty), pediatric fellowships, disadvantaged health professions students, health administration traineeships. health career opportunity programs at the following schools: Case Western School of Med, Bolton School of Nursing, Cleveland State University Nursing, Cuyahoga Community College Metro Campus, and the Ohio College of Podiatric Medicine.

Has your program benefitted in any way from these programs--for example--has it been easier to attract providers (primary care providers, nurses, etc.) to your (Center) because these programs exist in the area?

Does your center have formal linkages or collaborate with these programs in any way?--for example--Does your center serve as a training site for undergraduate and graduate students or provide mentors for students, participate in "grand rounds" on maternal and child health issues at Case Western or Bolton?

Do providers at your center have greater access to continuing education and other training programs because these programs exist in the area?

Has your center developed or entered into other relationships or participated in other activities because of your involvement with these programs ?--for example--participation in a community task force on MCH issues lead by Case Western--participation in a school based teen pregnancy prevention program that arose from linkages created through the health careers opportunity program at the school?

IV. COMMUNITY HEALTH CENTER PROTOCOL

A. INDIVIDUALS TO BE INTERVIEWED

CLEVELAND	
CHC PCAs , Columbus	Joseph Doodan
CHC PCOs, Columbus	Susan Ewing Ramsay
CHC Provider	John Campbell, Director Northeast Ohio Neighborhood Health Services
PHOENIX	
CHC PCAs AZ	Andrew Rinde
CHC PCOs AZ	Stan Hovey
HC Provider, Phoenix	Sylvia Eschave, Director Stock Mountain Park Health Center (receives HS funding, 330 funding, has school based clinics, 15-20 physician providers)
BOSTON	
CHC PCAs MA	James Hunt
CHC PCOs MA	Ann McHugh
CHC Provider	Jack Craddock @ East Boston Health Center Jackie Jenkins Scott @ Dimock Health Center Daniel Jay Driscoll: Director Harbor Health Service James Luisi: Northend Health Center Ellen Hafer (in Quincy) Manet Health Center Dr. Azi Young: Mattapan Health Center

B. INTERVIEW GUIDE

B.1 FEDERAL CONTACTS: HRSA INFORMANTS

1. One of the ways HRSA programs begin collaborations is through the grant application process. Can you give me an overview of the application process for Community Health Center funds? Do CHCs work with other partners in developing the application? Are there explicit, or implicit partnerships that the federal government is trying to foster, for example, with types of provider institutions, non-health social service agencies, community-based providers? Please tell us what is explicitly required and what guidance you are given. In sum, what are the expectations and how are they conveyed?

2. In what ways can HRSA grants be used to prepare CHCs for system changes? For instance, what requirements exist that strengthen CHCs and help them prepare for health system changes?

3. Have managed care and other market changes, such as mergers and reorganization of Academic Health Centers, begun to impact Cleveland Community Health Centers? In what ways? Have these changes affected CHC partnerships or collaborations?

4. Can you give us a sense for how the program is functioning; any problems, challenges, or successes particularly related to linkages to other HRSA programs, or non-HRSA health providers or agencies?

B.2 STATE CONTACTS: PCAS AND PCOS

Relationship with HRSA

1. Can you describe the activities conducted by the PCA/PCO? Can you describe how the PCA/PCO works with HRSA and CHCs to meet community health care service and educational and training needs?

2. What aspects of HRSA leadership and direction enhance the organization and the operation of PCO, PCA and CHC activities? Are there elements of HRSA program requirements that make collaboration more challenging?

3. Beyond the HRSA requirements, do you have performance requirements from other funders? What are they? How do performance requirements contribute to the delivery of program services?

Collaborations

4. From your perspective, have there been any other additional spin off effects of HRSA funding to PCOs, PCAs and CHCs in the Cleveland area such as leadership development, policy

development, quality improvement, expanded services, new collaborations, infrastructure development, training and continuing education?

5. Are there additional partnerships that would enhance service delivery but do not exist? Why do you think these linkages do not exist?

6. [For PCOs] Are CHCs partners in the process of determining the State's unmet needs?

7. [For PCOs] Do you believe that the expectation to maintain a relationship with health profession schools in the State enhances your ability to assist or advise CHCs in recruiting health care providers to medically underserved areas of the state?

8. [For PCOs] What is the relationship between PCOs and health departments? How do cooperative agreements contribute to this relationship? Are there additional spin-off effects resulting from the cooperative agreements?

Market Changes

9. Have managed care and other market changes, such as mergers, begun to impact the delivery of services in Cleveland? In what way? How have changes in the market environment impacted the delivery of care provided through Community Health Centers and other programs that serve the underserved (HRSA programs)? Have these changes affected program partnerships or collaborations in either a positive or a negative way?

10. Changes in the size of the "safety net" have resulted in a question of which organizations, agencies and/or programs comprise the safety net now and how shrinking in some parts of the net is putting more pressure on other traditional safety net services. How do you see these changes affecting the way in which Community Health Center program activities are conducted?

B.3 PROVIDER QUESTIONS

General Information and Grant Application Process

1. Can you briefly describe the activities of your center?

2. What proportion of your program activities are supported by Community Health Center funds? In addition to CHC funds, do you receive other HRSA or federal funding for health center activities and initiatives? Are the requirements for different HRSA grants complimentary or contradictory to one another? Please describe.

3. One of the ways that HRSA programs begin collaboration is through the grant application process. Did you lead the Community Health Center grant application process? If not, who

were your partners and what role did you play? Did the process lead to new collaborations among groups that were not previously linked?

4. How was information collected during the application process? Was this information shared with other community partners. For example, is data collected regarding community health problems and risk factors shared with other community health providers or planners? Who was involved in providing information necessary for the completion of the application? During the application process, did you feel that you had the capacity (for example, adequate staff) to complete the application?

On-going Collaboration

5. The next several questions refer to specific collaborations and partnerships that grew out of program activities subsequent to the grant proposal process. How do such collaborations come about? What do you feel programs and organization need in order to cultivate health partnerships (e.g. adequate staff to pursue linkages or sit on committees, requirements from funders to collaborate, etc.)?

6. Does the CHC interact with other HRSA funded programs in the (Healthy Start, Ryan White, Health Care for the Homeless, health professions training)? What do these linkages accomplish? Are there benefits to the co-existence of multiple HRSA programs in a community? Do- you collaborate or coordinate with Health Departments at the state or local level?

7. Do CHC representatives participate in any task forces associated with empowerment zones, Healthy Start or others? Are these collaborations important to the CHC? Can you describe your strongest collaboration in terms of the frequency of participation and the help it gives you in running your program?

8. Are there additional partnerships that would be beneficial to the program but do not exist? Why do you think these linkages do not exist? Did CHC requirements play a role in hindering these linkages?

9. In addition to the services you provide with HRSA funds, have there been any additional spin off effects (such as leadership development, policy development, quality improvement, expanded services, new collaborations, and infrastructure development, training and continuing education)?

Market Changes

10. Have managed care and other market changes, such as merger, begun to impact the delivery of Community Health Center services? In what way? How have changes in the market

environment impacted the delivery of care provided through Community Health Center funding? Have these changes affected program partnerships or collaborations in either a positive or a negative way?

11. Changes in the size of the "safety net" have resulted in a question of which organizations, agencies and/or programs comprise the safety net now and how shrinking in some parts of the net is putting more pressure on other traditional safety net services. How do you see these changes affecting the way in which CHC program activities are conducted?

12. Do you envision the need to develop new partners to help you implement these changes?

13. Does your CHC currently have any arrangements/contracts/agreements with any managed care organizations? Please describe.

14. Have HRSA funds positioned your CHC to respond to health system changes? In what ways? For example, have HRSA funds strengthened your linkages to other local CHCs, or have the funds enabled you to build a stronger infrastructure that will facilitate participation in a managed care environment?

15. Have HRSA requirements created barriers or hindered your ability to respond to health system change or to create more effective linkages?

16. Can you give us a sense of how the CHC program is functioning here; any problems, challenges or successes? How do you see your program changing, if at all, over the next 3 to 5 years?

17. The next set of questions refer to health personnel training and resource issues. HRSA supports a variety of training activities in the (Cleveland) area.

Interviewer: (FYI--HRSA funds support the training of nurses, nurse practitioners, nurse midwives, family medicine physicians (student and faculty), pediatric fellowships, disadvantaged health professions students, health administration traineeships, health career opportunity programs at the following schools: Case Western School of Med, Bolton School of Nursing, Cleveland State University Nursing, Cuyahoga Community College Metro Campus, and the Ohio College of Podiatric Medicine.

Has your program benefitted in any way from these programs--for example--has it been easier to attract providers (primary care providers, nurses, etc) to your (Center) because these programs exist in the area?

Does your center have formal linkages or collaborate with these programs in any way?--for example--Does your center serve as a training site for undergraduate and graduate students or provide mentors for students, participate in "grand rounds" at Case Western or Bolton?

Do providers at your center have greater access to continuing education and other training programs because these programs exist in the area?

Has your center developed or entered into other relationships or participated in other activities because of your involvement with these programs ?--for example--participation in a community task force on MCH issues lead by &se Western--participation in a school based teen pregnancy prevention program that arose from linkages created through the health careers opportunity program at the school?

V. TITLE V PROTOCOL

A. INDIVIDUALS TO BE INTERVIEWED

	CLEVELAND
Title V State Level Director	Kathryn K. Peepe
Title V State Level Provider	Cleveland MetroHealth Hospital, Child and Family Health (Dr. James Quilty)
Title V Regional Planning Consultant	
CISS Application Information	None
	PHOENIX
Title V State Level Director	Marianna Bridge
Title V State Level Provider	Child and Family Health (Karen Hughes, Bureau Chief) Children with Medical Handicaps (Dr. Jim Bryant, Bureau Chief)
Title V Regional Planning Consultant	
CISS Application Information	Linda Simpson Marianne Bridge
	BOSTON
Title V State Level Director	Deborah Klein Walker
Title V State Level Provider	Lillian Shirley: Exec Director. of PH Commission Jim Hunt & Ms. Pat Edroas, Mass League of Community Health Centers Matt Fishman @ Brigham's and Women Partners (hospital contact) Dimock CHC (Jackie Scott Jenkins and/or Joan Pemice) Jamaica Plane Health Center, Paula McNichols Martha Elliot Health Center, Dr. Joe Carillo Linda Shepherd (find out where she is from) Diana Christmas
Title V Regional Planning Consultant	Barbara Tausey
CISS Application Information	Boston Medical Center, Dr. Barry Zuckerrnan and Janet Leigh

B. INTERVIEW GUIDE

B.l TITLE V STATE AND LOCAL DIRECTORS

(Questions are to be asked of both state and local directors unless otherwise specified.)

Grant Application Process

1. One of the ways that HRSA programs begin collaboration is through the grant application process. In the Title V grant application there is a large emphasis put on collaboration in the planning process. There is also mention of a five-year more intensive planning process. Can you tell me about the planning process for the Title V Block Grant Application? Did the process of obtaining Title V funding cultivate any new partnerships or community coalitions with other HRSA-funded programs or with non-HRSA funded community programs such as WIC, or IDEA (an early intervention program for infants?)

2. How was information collected during the application process? Was this information shared with other community partners? For example, is data collected regarding community health problems and risk factors used for purposes beyond Title V, such as other community health program planning? Who was involved in providing information necessary for the completion of the application? During the application process, did you feel that you had the capacity (for example, adequate staff) to complete the application? In your view, why are some cities more capable than others to fulfill application requirements? Did you find the application process to be a useful exercise? (Explain that we are trying to understand the extent of importance of the grant development process resulting in something meaningful.)

3. Do you think the partnerships that are required by the Title V Block Grant Application would have been created if they were not required? What do such linkages accomplish for your program? Do such partnerships help you in your ongoing work? How?

Ongoing Collaborations

4. The next several questions refer to specific collaborations and partnerships that grew out of program activities subsequent to the block grant proposal process. How do such collaborations come about? What do you feel programs and organizations need in order to cultivate healthy partnerships (e.g. adequate staff to pursue linkages or sit on committees, requirements from funders to collaborate, etc.)?

5. Does the Title V program interact with other HRSA funded programs in the community? How about with other, non-HRSA funded community-based programs such as WIC and IDEA? In what ways do they interact? What facilitates or prevents interaction among HRSA funded and

non-HRSA funded programs? Are there benefits to the co-existence of multiple HRSA programs in a community?

6. Do you participate in any task forces associated with empowerment zones, Healthy Start or others? Are these collaborations important to your program? Can you describe your strongest collaboration, in terms of the frequency of participation and the help it gives you in running your program?

7. Are there additional partnerships that would be beneficial to the program, but do not exist? Why do you think these linkages do not exist? Did Title V requirements play a role in hindering these linkages?

8. Have there been any other additional spin off effects of your planning activities (such as leadership development, policy development, quality improvement, expanded services, new collaborations, infrastructure development, training and continuing education)?

Market Changes

9. Have managed care and other market changes, such as mergers, begun to impact the delivery of Title V services? In what way? How have changes in the market environment impacted the delivery of care provided through Title V funding? Have these changes affected program partnerships or collaborations in either a positive or a negative way?

10. Changes in the size of the "safety net" have resulted in a question of which organizations, agencies and/or programs comprise the safety net now and how shrinking in some parts of the net is putting more pressure on other traditional safety net services. How do you see these changes affecting the way in which Title V program activities are conducted?

11. Do you envision the need to develop new partners to help you implement these changes?

12. How does the Title V block grant affect spending priorities in the community? HRSA programs often make certain aspects of a program a priority. Do you feel this, in turn, impacts the way the community sets its own agenda with regard to program activities and funding allocation?

HRSA's Role

13. HRSA sponsors many community-based programs. Looking at your program, do you feel there are HRSA requirements that contribute to the delivery of program services, or ones that create barriers for more effective collaboration? Are the requirements for different HRSA grants complimentary or contradictory to one another?

14. Are there explicit, or implicit partnerships that the federal government is trying to foster, for example with types of provider institutions, non-health social service agencies, community-based providers? Please tell us what is explicitly required and what guidance you are given. In sum, what are the expectations and how are they conveyed?

5. Are the performance measures and reporting requirements helpful? How do you expect to respond to the data requirements of performance measurement that will be required for Title V beginning in fiscal year 1999? Do you have such performance requirements from any other funders? What are they?

Wrap-up

16. Can you give us a sense of how the Title V program is functioning here; any problems, challenges or successes? How do you see your program changing, if at all, over the next 3 to 5 years?

B.3 PROVIDERS

1. Can you briefly describe the activities of your program?

2. What proportion of your program activities are supported by Title V funds? What services do you provide with Ryan White funding?

3. What are your other funding sources? For example, do you apply to other HRSA programs? Are the requirements for different HRSA grants complimentary or contradictory to one another? In what ways has Title V funding helped attract other funds or provided core support that enables you to provide specific services?

4. Were you involved in the Title V grant application and planning process? What role did you play? What was the planning process for the application? Did the process lead to new collaborations among groups that were not previously linked?

5. The next question refers to specific collaborations and partnerships that grew out of Title V Block Grant requirements and program activities. First, can you talk a little bit about the purpose behind the linkages that exist to enhance the Title V program? (Specifically, do you collaborate with the Health Department at the state or local level? How do collaborations come about and what do you feel programs and organizations need in order to cultivate healthy partnerships? Do your linkages with other HRSA, with non-HRSA programs, with government agencies, and with provider institutions have different purposes? What are they?

6. Have you developed new partnerships as a result of your participation in the Title V program? Would these exist without Title V funds? What do these linkages accomplish? Do you have a sense for why partnerships exist at all?

7. In addition to the services you provide with Title V funds, have there been any other additional spin off effects (such as leadership development, policy development, quality improvement, expanded services, new collaborations, and infrastructure development, training and continuing education)?

8. Have managed care and other market changes, such as mergers, begun to impact the delivery of Title V services? In what way? How have changes in the market environment impacted the delivery of care provided through Title V funding? Have these changes affected program partnerships or collaborations?

9. Before we end, I would like to ask about health personnel training and resource issues. HRSA supports a variety of training activities in the (Cleveland) area.

Interviewer: (FYI--HRSA funds support the training of nurses, nurse practitioners, nurse midwives, family medicine physicians (student and faculty), pediatric fellowships, disadvantaged health professions students, health administration traineeships, health career opportunity programs at the following schools: Case Western School of Med, Bolton School of Nursing, Cleveland State University Nursing, Cuyahoga Community College Metro Campus, and the Ohio College of Podiatric Medicine.)

Has your program benefitted in any way from these programs--for example--has it been easier to attract providers (primary care providers, nurses, etc) to your (Center) because these programs exist in the area?

Does your center have formal linkages or collaborate with these programs in any way?--for example--Does your center serve as a training site for undergraduate and graduate students or

provide mentors for students, participate in "grand rounds" on maternal and child health issues at Case Western or Bolton?

Do providers at your center have greater access to continuing education and other training programs because these programs exist in the area?

Has your center developed or entered into other relationships or participated in other activities because of your involvement with these programs ?--for example--participation in a community task force on MCH issues lead by Case Western--participation in a school based teen pregnancy prevention program that arose from linkages created through the health careers opportunity program at the school?

VI. AHEC PROTOCOL

A. INDIVIDUALS TO BE INTERVIEWED

Site	State Representative	Local Provider
Cleveland	Cathy Vasquez	Susan Wintz, Case Western
Phoenix	Don Proulx	Georgia Hall, Maricopa AHEC
Boston	Michael Huppert	Dr. Peter Shaw, Boston University Michelle Urbano, Boston Medical Center

B. INTERVIEW GUIDES

B.1 FEDERAL CONTACTS

(not to be interviewed)

B.2 STATE AHEC DIRECTORS

(not to be interviewed)

B.3 AHEC PROGRAM DIRECTORS

Program and Funding Streams

1. Please describe your AHEC 'program. (Mission of program--probe for how activities in residency and graduate training, continuing education, undergraduate health careers training and community health education are provided to meet the needs of the community. Are there activities in all areas or has the program focused on just one area? Why?)

2. How long has the program received AHEC funding? What portion of total funding does AHEC funding currently represent? Does the program receive other federal funding? (What type--identify other HRSA funding). Some AHECs have experienced significant reductions in funding. Have community collaborations, private foundation grants, and other sources been tapped to maintain the program? Please describe. Do you apply for other HRSA grants? Are the requirements for other HRSA grants complimentary or contradictory to one another?

Planning Process

3. Please describe your partners in developing the AHEC application. Probe for higher education partners, hospitals, health departments, community-based providers, high schools and advisory board/commission partners. Who is on the AHEC board (get a list of board members)?

4. Did these partnerships previously exist or were they developed as part of the application process? (Identify the 501 C-3 community based organization partner-explicit partner and relationships with PCAs and PCOs). Are there other implicit partnerships or collaborators? Has the AHEC program allowed you to cultivate partnerships that did not already exist? How did these partnerships come about? What do you feel programs and organizations need in order to cultivate health partnerships (adequate staff to pursue linkages or sit on committees, requirements from funders to collaborate).

5. What process is in place for identifying community health care provider education and training needs? Who are your partners in this process?

Linkages with Other Programs

6. Please describe any relationships the program has developed with Community Health Centers and other health agencies/organizations. (Do linkages or collaborations exist with Academic Medical Centers, hospitals, managed care plans, and Health Departments at the state and local levels?)

Response to Market Changes

7. Have managed care and other market changes such as mergers and realignment of health care providers begun to impact the AHEC program. In what way? Have these changes affected program partnerships or collaborations?

8. Have changes in the "safety net" had a repercussion on education and training needs? How do you see these changes affecting the way in which the AHEC conducts its activities?

9. In addition to the education and training services the AHEC program provides in the community, have there been any other additional spin-off effects (leadership development, policy development, quality improvement, infrastructure development or sharing, new programs that have spun off)?

HRSA Relationships

10. HRSA sponsors many community-based programs. Looking at your program, do you feel there are HRSA requirements that contribute to the delivery of educational and training services. or ones that create barriers for more effective collaboration?

Wrap-up

11. Can you give us a sense of how the AHEC program is functioning here; any problems, challenges or successes? How do you see your program changing, if at all, over the next 3 to 5 years?